Vulnerability and Identity Negotiation in Childbirth: A Narrative Approach.

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Abstract

Despite knowledge and policy support of the positive contributors to a woman's birth experience and awareness of the lasting impact of her interpretation of the event, there is a distinct lack of acknowledgment in the childbirth literature of the woman's exposure to a vulnerability characteristic of birth. I feel that this transient experience of vulnerability exposes a woman's identity to subliminal messages about her body, her competence and her social positioning, while the physicality of birth is foregrounded. I believe women use the telling of their birth stories to make meaning out of their experience.

To analyse the identity work of the story, I selected 20 birth stories from a popular 'mums' internet forum. Using a multi component narrative analysis technique, comprising structural, thematic and discourse analyses, I have been able to explore the influence of competing discourses upon woman's experience of birth in the UK. In complement I have woven my story of transition to motherhood into the project to chart my subjective position as it evolved with the development of this project.

This project has contributed evidence to the discussion of women's experiences of subjectivity in the discursive landscape of birth, while uncovering previously unacknowledged sites of resistance. The linguistic restrictions, sustained by the neoliberal control mechanisms on society and the self, act to shape the reality, feelings and expressions of birthing women. Naming these silencing strategies, as I have done through the findings of this project, and celebrating women's discourse on birth as the explosion of birth stories across the internet are doing, offer bold moves to challenge the muting status quo of women in birth. Reclaiming women's language for birth and working to create a new vocabulary encapsulating the experiences of birthing women, will also present opportunities for the issue of birth and women's experiences of it to occupy greater political space with a confident and decisive voice.

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Chapter 1 Introduction

This is a study of birth stories and the complex work they do to position their storyteller within her experience of giving birth. Unlike earlier work with birth stories that concentrated on identifying components of positive or negative birth experiences, perceptions of choice, shared decision making or compassionate care (Bylund 2005, Hastings-Tolma et al 2018, Hirschenfang 2011, Kay et al 2017, Mosier 2016, Munro et al 2009, Tumblin 2013, Weston 2011), this project develops the novel perspective of analysing birth stories through a broad lens of social identity theory and acknowledgement of vulnerability during birth to explore the work done by the story (Carson et al 2017, Hastings-Tolma et al 2018, Simic 2014). Here the focus is on the interdependence between the expectations and actual experience of the storyteller during birth, her perception of the audience to her story, and the consequent story construction and positioning of the storyteller within this relational network.

Using 20 systematically selected birth stories posted on an internet-based mother's discussion and information forum, I apply the techniques of narrative analysis. I first explore the structural elements of the story, describing the use of different structural components and what this may reveal about the messages in the story. Secondly, I examine recurrent patterns and variations across the data set in a thematic analysis to explore potential commonalities in the experiences storied. Thirdly, I consider how the stories have been co-constructed with the storyteller's audience and the wider discourse on birth within society, through the use of dialogic analysis techniques.

In this introductory chapter I will explain the development of my interest in vulnerability in childbirth, its impact on the identity development of the storyteller and how this may be presented through the birth story. I will describe the discursive context of birth within the UK to situate my project and give a brief outline of the analytical frameworks that I draw upon to structure my approach to the research question.

1.1 Background

At registration in 2012, my PhD question was framed around the professional response to feedback from women in labour, with an eye on dignity in childbirth and the gap between expectation and reality. This was as a result of my experience as a student midwife, working with mothers who were often dissatisfied with their birth experience. The maternity service in

the UK has a lot of information for staff and service users based on policies supporting choice, control and continuity in care. These are enshrined in the call for reform of maternity services in the Changing Childbirth report of 1994 (DOH 1994). This insisted that maternity care be woman centred, and that choice, continuity and control should inform the development of services. This reform was audited in 1997 and a parliamentary sub-committee was convened in 2003. Despite reports that choice had improved, there was still a significant number of women reporting that they did not always feel in control of what was happening to them (60% of the sample), with an increase in mothers using epidural pain relief as they lacked confidence in their ability to cope without it (DOH 2004). The latest government commission reporting on maternity care provision 'Better Births' (DOH 2016) focuses on choice of birth place and continuity of care as principal quality measures. However, general feedback from respondents resulted in an acknowledgement that women do not always feel like choice is theirs and too often they felt pressurised by their midwife or obstetrician to make choices that fitted available services. This suggests the policy rhetoric continues to struggle to impact significantly on practice. I felt there were numerous institutional and culturally constraining factors at play in this context that I could explore in my PhD question. I had planned to explore women's birth stories to tease out those quality criteria from the perspective of birthing women, supplemented by focus groups with student midwives to look at how the birth worker responded to women's feedback in labour.

Following a 2-year break with the birth of my own two children, I reviewed the corpus of work I had accumulated and felt the 'quality' in birth field to be so complex and subjective that I was not really addressing anything new. Reflecting on the time delay from the original formulation of my question and the life change I had experienced in that period, I realised that my alignment in the midwife-woman dyad had firmly reoriented from professional to that of a birthing woman. Fundamentally, I now appreciated birth as a life changing experience as opposed to a life changing event, the difference of which I shall explore later. Rereading my initial literature review, I felt something was missing. In my birth experiences, I felt my position to birth with minimal intervention was precarious and dependent on those around me. This left my birth experience, and my self, vulnerable to disruption. This reflection directed me to explore the literature on vulnerability as a potential link or contributor to the birthing context I was exploring through my research question that I had not read about in my previous preparatory searching of the maternity literature.

Realisation of my fully participative, personal involvement in the interpretation of my project data positioned me as an insider, sharing the experience of my project participants in juxtaposition to my previous role as a childless midwife with no subjective experience of the birthing phenomena. This has naturally changed my relationship with the data and the depth

of my reflective approach that has transparently enlisted the methodological support of critical autobiography to document the evolution of my identity over the 6 years of this project and the social and cultural ways of knowing informing this transformation (Polkinghorne 1988). By experiencing the physical sensations of birth overwhelm my conscious ability to control the environment around me, I reviewed my actions as a midwife in births that I had attended. I had enrolled on the 18month midwifery course with almost 15 years of socialisation as a nurse. I felt my communication skills were strong in building rapport, communicating confidence, empathy and reassurance across the illness journey, age and ethnicity categories. I had done counselling and palliative care and felt I knew how to actively listen. But as a student midwife I felt the nursing skills I had learned and been socialised into from the age of 17 did not reach a woman deep in labour. I had to stand back, to be there but wait and watch, to learn presence and 'guardianship' and stop 'doing'. I'd read about this, seen some midwives practice in this way but my internal anxieties about what might go wrong raced around my brain and surely counteracted any efforts at calm, confident presence.

And then I experienced labour myself. My first birth moved from the calm of home in a protracted second stage to the delivery suite of the local hospital. I could see anxiety and activity all around me as I was bombarded with instructions and interventions. This confused and derailed my confidence. I was giving birth, not a victim of a major trauma requiring 8 people in the room shouting instructions to each other like a scene from 'Casualty'. I fundamentally felt everything was okay and my body was in control but I definitely felt out of control and at risk of decisions being made for me. I wanted everyone to stop talking, to go away and to let me, my husband and the midwife traverse the route to birth together. I was too busy managing my contractions to verbalise any of this. But the midwife did, she told them I was going to do it and for everyone to leave. I will never forget her. Actually, I will never forget her confidence and calm belief. It reminded me and reoriented me back to mine. My second birth was at home and I had the calm confidence and belief of the first birth without having to block out the bustle. I stopped making small talk with the attending midwife because I had to retreat into my body and give it full attention to give birth. Furthermore, I appreciated the physical experience of birth had been beyond words I had to describe. These realisations impacted how I saw my 'self' in relation to the expectations of birth I had held pre-nataly. I instinctively turned to the telling and retelling of my birth story to try and make sense of what I had experienced in comparison to what I thought I had prepared myself for. Consequently, this emic perspective and narrative process changed the way I read and interpreted my data.

My original project focus on dignity was an attempt to explore a way to humanise the technocratic birth system from an outside perspective. But birthing, from both inside and outside that technocratic system made me look for something deeper that contributed to a woman's positive perception of her birth experience. A lot of work has been done on continuity of carer and knowing your midwife, on shared decision making and control. It took me until the write up of my analysis to interpret these concepts as the defence against vulnerability. My literature review had laid out a context of vulnerability through exploration of common expectations for birth that dug down into their potential sociological and historical origins. I am certain that if I had never experienced labour, this project would read very differently as your experience affects the outcome (Letherby 2003).

1.2 Context for the study

To help situate the birth stories analysed for this project, I will briefly present the context of birthing services within the UK. As mentioned in the introduction, the radical 'Changing Childbirth' report accepted as legislation in 1994 set the benchmark for a new woman centred service that focused on choice, control and continuity. With relation to location of birth, the maternity standard of the National Service Framework for children, young people and maternity services confirmed:

'every woman should be able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical or obstetric needs she and her baby may have' (DOH 2004)

Within this background of choice, control and continuity in both location and content of maternity care, birth place distribution reflects the dominant service model within the UK. The majority of births in 2015, the most recent year for which statistics are available, took place within an obstetric unit (OU) located in the hospital (92%); with 2% in a free-standing midwifery unit (FMU) and 2.1% planned home births with midwifery attendance (ONS 2017).

The current context of birthing within the UK has been shaped by over 200 years of inter group conflict between midwives and the medical fraternity, characterised by a feminist struggle for a place in the privileged world of education and technological practice. This context has evolved within a geography of rising institutional power and dominance of the medical grand narrative within society. An understanding of the historical landscape is essential to appreciate what women step in to when entering the birthing 'system'.

1.2.1 Historical Context of birth in the UK

Rivalry began around 1720 when the ‘midwifery forceps’ were introduced and used by male barber surgeons. The dangers of childbirth were emphasised and the forceps were advertised as expediating long labours and difficult deliveries. Consequently, their use became fashionable among ladies who could pay the fee. The male attendant with his equipment and requirement for on the bed delivery became associated with high class fashion. Conversely, midwifery attendance and out of bed or upright birth became labelled as low class and barbaric. Women midwives soon began to lose their credibility as the male medical skills were always credited with saving the woman’s life (Donnison 1988).

By the late 19th century medical men were seeking to control all of obstetrics as a route to their own professional acknowledgement in the emerging profession of general practice. Alongside their use of instruments at delivery was their exclusive knowledge of anatomy which was the key to skilful practice. After an unsuccessful battle by midwives to be responsible for attendance on all birthing women, a new tactic was taken to broker a compromise and ensure protection of the normal domain of childbirth for midwifery practice. The preoccupation of the midwifery radicals was in securing their place in a medically controlled and dominated field and moved the focus from the preference and needs of birthing women to the creation of a respectable profession for educated women (Donnison 1988). Thus, with the patronage of supportive medical professionals, the midwifery radicals achieved their compromise in an era where women did not yet have the political vote and held precarious public power in society. The compromise allowed this select group of women to enter the public domain of midwifery practice under the control of the medical profession but only to attend normal births. Such an agreement prevented midwifery being forced out of legitimate practice by the expansion of general practice physicians into the growing field of obstetrics.

This compromise became enshrined and legally sanctioned in the Midwives Act of 1902. It decreed all uncomplicated birthing women were to have trained midwifery attendance by 1910. This law legitimized the role of the trained midwife in public practice while moulding the profession through education and licensure to reflect the dominant values of the science based medical profession (Mander 2004). Thus, conditions of the institution were imposed upon the midwives and their social model of birth practice under the guise of professionalisation. Institutional accountability has since become a significant director of practice as midwives must adhere to the policies and procedures of the organisation to which they are contracted (Tronto 1993). While securing a respectable profession for

educated middle class women, the traditional attendants previously called for at delivery, were pushed out of practice. These women did not share the educative privileges of the powerful group of midwifery radicals and were seen as fair sacrifice to secure the new profession of trained midwives (Tajfel 1974). Midwives were now formally mandated to look after women experiencing normal childbirth and would call the doctor if there were any complications.

This historical dominance of midwifery by the medical profession is felt to remain a major impediment to its current practice (Hyde & Roche-Reid 2004). In the context of institutional midwifery practice today, midwifery is described as focusing on normal birth in response to increasing medicalisation (Dornan 2008). However, the culture of risk that controls practice has eroded the boundaries of normality through continuous surveillance for an imagined hazard that may occur in the future (Keating & Fleming 2009, Scamell 2011, Scamell & Alaszewski 2012). The very process of monitoring has been found to disturb normality and stimulate the woman to question her own birthing ability (Scamell 2011), yet many midwives describe it as beneficial (Scamell & Alaszewski 2012). Interviews with midwives have revealed a shared notion of normality only in hindsight when the crisis of labour has passed. This is despite perceptions of their role being consistent with the midwifery discourse around woman centred care, facilitating the woman to achieve control, and belief in the ability of her body to birth her baby (Hyde & Roche-Reid 2004, Scamell 2011, Scamell & Alaszewski 2012). Inability to facilitate a woman's choice is commonly blamed on Institutional policies and procedures, and the obstetrician's ultimate responsibility for activity within the labour ward (Hunter 2012, Hyde & Roche-Reid 2004, Keating & Fleming 2009). This accountability hierarchy values technical skills over intuition (Keating & Fleming 2009, Shallow 2001).

1.2.2 Current system of birth in the UK

Currently within the UK, a woman will 'book' with a midwife once she has discovered she is pregnant. Following this risk assessment and information giving appointment, the woman is then given a schedule of antenatal check-ups with the midwife, with the midwife or GP if there is a shared care agreement or with an obstetrician if she is classified as high risk. This booking appointment will give her information on different exercise and birth preparation classes run by the NHS or charities such as the National Childbirth Trust, in addition to a range of different advice leaflets about health in pregnancy (diet, exercise, immunisations, anxiety & depression), breastfeeding, perineal massage, pelvic floor exercises, infant care etc. Birthplace choice is also introduced at this appointment (NICE 2018).

1.2.2.1 The technocratic birth model

Once a woman's labour starts, the majority (92% according to the ONS 2017) will present at the hospital to be cared for by one midwife, with a second midwife attending at the point of birth to provide support for the new baby. Care is overseen by the obstetrician who will review progress based on midwifery feedback and intervene in the instance of complications. Women choosing hospital birth cite safety as the primary reason, 'in case something goes wrong', while being aware of the increased risk of intervention (Green et al 2007).

However, a blurring of practice lines means 'active management' of the woman's labour is common, often supported by the senior midwives to rush women through the department. This is despite an awareness that interventions are not always evidence based (Hunter 2012, Hyde & Roche-Reid 2004, Keating & Fleming 2009, Scamell 2011, Scamell & Alaszewski 2012). Consequently, institutional midwifery is increasingly described as 'medicalised' or technocratic, absorbing technical interventions into the experience of 'normal' birth, to the extent that even the definition of normal birth has become ambiguous (Clarke et al 2007, Downe et al 2001, Guiver 2004, Mead 2004, Romano & Lothian 2008). A sub analysis of the Birthplace data (Brocklehurst et al 2011) revealed intervention rates in planned obstetric unit (OU) births to be greater during 'office hours' in comparison to overnight in low risk nulliparous women. Interventions, such as induction and augmentation, were recorded as highest during the end of 'office hours'. Rates of the most invasive intervention, the caesarean section, were lower among first time mothers during 'office hours' in comparison to overnight. This context has been shown to lead to feelings of frustration among midwives, disempowerment and even a reason for leaving the profession (Ball et al 2002, Hyde & Roche-Reid 2004, Keating & Fleming 2009,). Some midwives described feeling unsupported by their colleagues (Gillen et al 2008, Kirkham 1999) and even at risk of ridicule for not conforming to the medical model (Keating & Fleming 2009). In contrast, some midwives preferred this institutional model of childbirth to protect the self emotionally against the demands of forming close relations with birthing women (Finlay & Sandall 2009, Hunter 2012, Kirkham 1999).

In a technocratic culture, values stem from the authority of technical experts, interpreting the data produced and acting on its findings. The dominant themes of childbirth in this model are risk, pain and the routine use of invasive procedures. Women's expectations of childbirth have been charted as changing over time to reflect a process involving such medical interventions with less control and choice for the birthing woman during her birthing

experience (Johansen et al 2002). An increased willingness to accept intervention in childbirth was recorded in the comparison of a cohort of antenatal women from the UK between 1987 and 2000 (Green et al 2007). Furthermore, in a study of 50 women in Scandinavia, the hospital birthing group were more likely than the home birthing group to think procedures were necessary and to see specific technologies in a much more positive light (Kornelson 2005). Simkin (1996) controversially describes women as contributors to this rise of technocratic birth in their post war consumerist demands for pain free birthing. Those physicians not offering the 'twilight sleep' drugs were labelled as sadistic and 'anti woman', as pain was equated with danger and risk.

As a result, technocratic birthing can be described as the norm with women increasingly lacking understanding of their body's own capacity to give birth and the ability to critically assess birthing options and actively select their care setting and provider. An assumption that care received is of high quality and in their best interest, coupled with a lack of awareness of maternity rights and evidence-based practice can create a feeling of vulnerability and dependence on the authority of 'expertise' that is grounded in an esoteric but objective body of knowledge (Klein et al 2006). Rose (1999) develops Foucault's theory of biopower (2008) to attribute this authority of the knowledge of experts to the aspirations of government over individual's life projects. He credits them with forging new alignments between the techniques of power and the values of a democratic society that promotes autonomy. Thus, subjectivity is governed in three different ways to shape the lives of individuals through the 'choices' they make to fulfil a eugenic desire for perfection that reflects a modern-day concept of health. This governmentality operates through the persuasion of its truths; the anxieties stimulated by its norms; and by the attraction of the images these 'truths' offer to the self (Coxon et al 2014, Possamai-Inesedy 2006). Within a birth context, this is illustrated by the concentration of experts on compliance with risk averse guidelines that focus on the threat of risk or harm to the baby (Talbot 2014).

On an individual level, this perspective of power relations in society is described by Rose (1999) as governing the soul. By recognising ourselves as a particular type of person, responding to the unease generated by normative judgement of what we are perceived to be and could become, we are prompted to overcome our inconsistencies by following the advice of experts in the management of the self. This self-regulating biopower emerges as benevolent, but is an invasive form of social control, characterised by regulatory policies and knowledge and power over the body (Chadwick & Foster 2014, Foucault 2008, Sawiki 1999). As a result, people begin to view their bodies with a medical gaze (Rothman 2014), informed and encouraged by the media (Klein et al 2006). The clinical intrusion is deemed acceptable as its objective is to promote health, as well as exercising disciplinary power (Holmes &

Gastaldo 2002). Consequently, women of childbearing age are aware of risks of miscarriage, prematurity, and genetic disorders. They are also made aware of factors that increase risk to the fetus such as smoking, drinking, drug use, increased age during pregnancy and unpasteurised or uncooked foods. This information reinforces the message that women's bodies are inherently faulty (Possamai-Inesedy 2006). Perceived and taken risks are judged by the woman herself and by others, leading to social comment on mothers who smoke or drink as indulging in bad behaviour (Rothman 2014). Furthermore, is the example of blame allocation to those who fail to inform themselves, illustrating a key characteristic of our risk society (Possamai-Inesedy 2006), with an additional social expectation that parents will inherently do the right thing (Coxon et al 2014). Sawiki (1999) expresses concern that the disciplinary functions of medical surveillance will produce new norms of motherhood, with a danger that the medical solutions will become the only solutions. This exposure to the judgement of others can influence the woman to try to fulfil those expectations. If they are not successful, the shaken confidence and feelings of failure can be turned inward increasing her vulnerability and sense of isolation from other women (Nilsson & Lundgren 2009). The review of maternity literature by Hallgrimsdottir & Benner (2013) highlights prevalent themes of risk and moral responsibility in the mother to know the risks and act accordingly to avert danger. Thus, there is no longer the concept of a healthy pregnancy but at best, a low-risk pregnancy.

The technico-scientific approach to risk is the hegemonic model, conceptualising risk as an objective phenomenon that can be controlled and predicted through science and expert knowledge (Chadwick & Foster 2013). Such a system is described as feeding on fear, defining each birth as a medical event (Klein et al 2006). Increased medical management gives an illusion of safety within this model while doing everything possible to reduce professional exposure to medico-legal risk (Coxon et al 2014, Simkin 1996). The language of risk permeating biomedical models of childbirth emphasizes expert and evidence-based knowledge, prediction and control (Chadwick & Foster 2013). The dependence on experts to furnish an individual with skills has arisen from the invasion of private life by bureaucracy (Rose 1999) leading to the question of who owns the woman's body, herself or the state (Oakley 1986). However, as birthing women express a need for medical support in childbirth, the obstetric profession demonstrate their reciprocal need for birthing women seeking safety through obstetric management to maintain their professional actuality. This reciprocal relationship perpetuates medical colonisation and objectification of birth despite reports of increasing dissatisfaction with the technocratic birthing model from women and an increasing awareness of related negative psychological and social consequences (Benoit et al 2010, Reed et al 2017, Soet et al 2003, Waldenstrom et al 2004,). Interestingly, Hallgrimsdottir &

Benner (2013) attribute the perseverance of the technology supporting risk narrative to the cultural embeddedness of social narratives related to the management and control of the female body, rather than to the advance of medical knowledge.

1.2.2.2 The Midwifery model

In contrast to the technocratic model of maternity care sits the midwifery model. This model is rooted in the relational philosophy of being 'with woman'. This underpinning philosophy will be further explored in the literature review chapter of this project. Midwives can deliver their model of care within the hospital labour ward, though this has been criticised as heavily influencing practice towards a technocratic model (Gould 2002); a midwifery unit (MU) or birth centre with a philosophy of, 'keeping the thought of complications in the back of the mind rather than the forefront' (Walsh 2007); or in the home. Midwifery units record low rates of intervention and a high proportion of normal births, however the average number of births per year is only between 100 and 300 per unit. There is significant regional variation in both availability of an MU and of their capacity (Brocklehurst et al 2011). Women choose to birth in an MU for a number of reasons including awareness of the increased chance of normal birth and of birth expectations being met, a homelier environment than the hospital, closer to home or family, or on recommendations from other women who have birthed in an MU (Walsh 2007). A significant constraint in choice of birthplace reported by participants in the Birthplace study (Brocklehurst et al 2011) was the distance between the MU and the OU when considering potential intra-partum transfer, and the associated disruption in continuity of carer.

Some women seek an alternative configuration of maternity care to facilitate their birth experience. This can be with the support of a doula to ensure receipt of continuous relational support, or take the form of a homebirth where the power dynamic is perceived as equalised (Kornelson 2005). Doulas are women who give support and advice to the birthing woman during and after birth. They have usually had children of their own and have completed some basic training, though do not have clinical skills. They can support the woman in the home or hospital context alongside the maternity professional. There is an accreditation system in the UK that records 700 members on its register (www.doula.org.uk). The Doula movement has received encouraging results as they reconnect with the old traditions of support in labour (Pascali-Bonaro et al 2004). Doula-supported mothers are more likely to report positive expectations for birth, the experience of support from others, positive self-worth, reduced analgesia and fewer interventions than women birthing without a doula (Campbell et al 2007, McGrath & Kennel 2008). The study by Campbell et al (2007) trained female relatives for 2 hours in support techniques and found similar outcomes. As increased self-esteem has been

linked to participation in a reciprocal relationship (Helliwell and Putnam 2004), this could explain the value of a known birth supporter among women that does not necessarily have to be a midwife. The role of the supportive birthing partner fits the ethos of the natural childbirth movement which emphasises the role of social support in building trust in oneself, in one's ability and in the natural process of birth (Mansfield 2008).

Homebirth is seen as a model that places the woman at the centre of the birthing process, that is grounded in connectedness and privileged forms of knowing including intuition, instinct and a belief in their capacity to give birth (Joukhi et al 2017). This attitude and approach destabilises the biomedical conceptualisation of the birthing body as solely a source of risk and potential dysfunction (Chadwick & Foster 2013) and sits as an empowered alternative to the dependence engendered by the biomedical model of maternity care (Hallgrimsdottir & Benner 2013). Within the literature, women choosing home birth constructed hospital birth as risky, with the birthing body vulnerable to objectification, a loss of dignity and being shamed (Chadwick & Foster 2013, Coxon et al 2014). As a result, hospital birth is no longer seen as the safest option among this group. Home birth is described as a way to resist the overuse of technology as institutional constraints are relaxed, to remain in control of decision making, the environment, caregivers and of herself, allowing herself to be present in her body (Aune et al 2017, Chadwick & Foster 2013, Coxon et al 2014, Kornelson 2005). In contrast, women transferred from home birth to hospital reported a sense of failure and negative perceptions of their experience (Kornelson 2005). This was reflected in a study by Geerts et al (2014) where women who were transferred in to hospital from home birth experienced a lower sense of control than those who were not transferred.

The Office of National Statistics measures the trend of homebirth from the 1960's to the present day. In 1960 it was measured at 34%, dropping sharply to about 3% by 1975 when the culture of birthing was firmly oriented to institutional birthing. The rate has remained largely unchanged since then, measuring 2.1% in 2016, the last year for which statistics are available. Within this cohort of birthing women, those aged between 36-39 are most highly represented (ONS 2017). The joint statement from the RCM and RCOG released in 2007 expresses support for home birth as a choice for women with an 'uncomplicated' pregnancy by obstetric criteria. They acknowledge the increased likelihood of a satisfying and safe birth and postulate a national home birth rate of 8-10% if women had true choice (Cresswell & Stephens 2007).

1.2.2.3 Other Resources

Despite a strong professional culture and legal requirement for professional attendance at birth, other sources of information have proved popular and influential in a woman's socialization for birth. The internet is labelled as a significant source of childbirth information among first time mothers followed by birth stories and experiences of friends and family (Carolan 2006, Declercq et al 2007, Lagan et al 2010, Martin et al 2013, Savage 2006). In a study by Lagan et al (2010) across 5 countries, the use of the internet in pregnancy was high among respondents. It provided support and reassurance between midwifery appointments or where health professionals did not provide enough information to meet their needs. The nature of internet searching allowed the cross checking of information across sites for consistency. This was frequently compared with their own beliefs and those expressed by family and friends. Importantly, the information that was acquired made respondents feel in control, informed and gave them the confidence to speak to health professionals as equals. This preparation has been described by respondents as helping them to make informed choices and feel 'in-control' in a situation where they would not know what to expect (Gibbins & Thomson 2001).

As well as factual sites on the internet, there are a plethora of online fora, blogs, and diaries sharing stories and discussing birth. These are run as online communities or by individuals, freely accessed or restricted to member only posting and originate from across the world. The demand for stories and the desire by women to share them is clear from a sub group of sites giving directions on how to write your birth story, why you should write it and what to do with it once it has been written. Within the academic literature, Remer (2011) describes how 'stories have had more power in my own childbearing life than most other single influences'. She wanted to hear others' stories and from them she learned more than from all the help books and professional advice that was available. Birth stories are frequently described as valuable by women as a source of information about the wide range of possibilities in birth. Furthermore, in the reading of stories online, the reader has the power to engage or disengage which may be more appealing than getting stuck in a face-to-face situation (Remer 2011).

1.3 Analytical framework

Despite knowledge and policy support of the positive contributors to a woman's birth experience and awareness of the lasting impact of her interpretation of the event, there is a distinct lack of acknowledgment in the childbirth literature of the woman's exposure to a vulnerability characteristic of birth. I had felt during my birth experience that I needed to

concentrate on allowing my body to give birth. Putting my trust in others to maintain that safe space to allow me to do this, made me realise how vulnerable my birth was to disruption and how precarious I felt as I negotiated my way through the experience. This realisation offered a new lens with which to view my project data, interpreting the birth expectations literature into an explanatory framework of birth vulnerability, as I took responsibility for interpreting the data from my new way of knowing (Walker 2017). I feel that this transient experience of vulnerability exposes a woman's identity to subliminal messages about her body, her competence and her social positioning, while the physicality of birth is foregrounded.

I realised, from my own experience and from the reading of many other women's birth stories, that these stories have a role in this meaning making process of the self. These stories do work. A woman's storying of her birth draws on the reflective resource of memory alongside her understanding and interpretation of the experience. These resources inform the processual revision of her body-self identity in engagement with the social world.

Contained within a birthing woman's engagement with the social world is the socially constructed expectations for birth that women carry in to their experience. This reference to the evolving self and social construction of expectations led me to the philosophical underpinning of this project. First and foremost this is a feminist project as I focus on the meanings women give to their world. By taking a narrative approach I access their words, their perspectives and their spaces. I celebrate the role and value of story in identity construction and as a communicative practice. Feminist research is characterised by its diversity and my project crosses the disciplines of sociology, anthropology, linguistics, history and philosophy to address the question. In so doing I aim to explore a power imbalance and produce social change, emancipating women by the naming of silencing factors and exploring the use of the body in birth as a site of resistance. Fundamental to my feminist approach is my rejection of the objective view and the inclusion of my self and my experience in this work. The evolution of my identity to include nurse, midwife, researcher and mother is documented throughout this project as I explore the influence of my personal knowledge on interpretation of the data and the conflict between my socially located and structured understandings of my self as a health professional and my lived experience as a woman (Ribbens 1993).

Using a critical autobiographical methodology (Walker 2017), I will situate this project in a symbolic interactionist framework by drawing on the theory of identity proposed by George Herbert Mead whose work from the 1930's has been collated into a definitive volume by Morris (2015). However, where Mead redefines the self as a product of socialization through role taking, I will explore the post structural enrichment of aspects of this interpretation.

Accessing the work of Judith Butler (1999, 2005, 2014, 2016), I will explore the external relations of discourse as constitutive of identity, constructed behaviourally through performativity. This complementary analysis of identity formation will allow for discussion of the dominant and alternative discourses at play in the negotiation of the subject-position of the birthing mother. These epistemologies will be held together by embodiment theory, to explore the features of how minded bodies and worlds fit together (Pitts-Taylor 2015). The realisation of my full, participative, personal shaping of my project data by connecting the findings with my lived experience as a mother drew me to the methodological framework of critical autobiography. This approach will allow me to examine the social and cultural ways of knowing that have shaped my identity over the 6 years of this project, transforming my interaction and interpretation of my project data (Polkinghorne 1988).

This complex matrix of identity formation will be explored through my analysis of a selection of women's birth stories. In light of this context I have reframed my inquiry, from an exploration of quality criteria in birth and the professional response to women's feedback, to instead look at the work of the birth story within the context of birth vulnerability and the processual development of body–self identity. This will be illustrated by the positioning of the storyteller in her experience.

Thus, I propose the following revised question, supported by 3 objectives:

Q. How do birth stories convey vulnerability in childbirth and how is this experience incorporated into the post birth identity?

Objective 1. To explore the concept of vulnerability in birth.

Objective 2. To explore childbirth as an embodied experience.

Objective 3. To explore the identity work of the birth story.

1.4 Outline of the thesis

Within this chapter I have introduced the theoretical framework upon which this project is based. I have outlined the development of my interest in vulnerability, identity and storytelling in childbirth, and I have mapped out what I aim to achieve by this project and how I plan to do it. Therefore, the remaining chapters are organised as follows:

Chapter 2 contains the literature review for my project and is divided into 3 sections: childbirth as an embodied experience; vulnerability in childbirth; and storytelling in birth. This review will contextualise my project within the wider literature. The first section firmly situates childbirth as an embodied experience. An experience leads to the participant gaining

knowledge. How this knowledge is gained emphasises a gender divide within society as the rational mind and objective knowing are associated with men while the feminine is linked to the reproductive body and emotional subjectivity. The literature is reviewed that intertwines the material and cultural in the formation of our embodied selves, making visible the varying experience of bodies, mediated by social positionality to constitute our sense of self. The influence of discourse and the emotions in sense-making is explored within the context of 'doing the body'. The second section – vulnerability in childbirth – views childbirth as a transitional experience, exposing the woman to a possibility of harm as she travels between social categories. Her social and physical vulnerability is presented within the anthropological rite of passage framework as described by Geertz (1973). This framework has three stages of separation, liminality and incorporation. During the liminal phase, the woman is vulnerable due to her potential interpretation of personal status during the birth experience and openness to learning of her new role in society. This learning is commonly achieved through the experience and interpretation of birthing rituals in conjunction with internalized expectations of labour and birth. Interpretation of these rituals are explored through the concept of exposure, inadequacy and unpredictability with an introduction to the transformative power of story. This leads in to the third section: storytelling in birth, where the story is described as the fundamental unit to account for the content of one's lived experience. Stories have been used to repair damage, restore order or reclaim experience from an alternative narrative. Which components will form the narrative introduces the role of memory and the dialogic interaction of the audience, exposing both a personal and social task in storytelling.

Chapter 3 is an account of the research methodology and method that I have used in the conduct of this project. I have identified the symbolic interactionist epistemology of Mead (Morris 2015) as the foundation of my approach, exploring the intersection of his theory of the self with narrative. However, where Mead redefines the self as a product of socialization through role taking, I explore post structural enrichment of this interpretation through the varying works of Judith Butler (1999, 2005, 2014, 2016). I explore the external relations of discourse as constitutive of identity and how they are constructed behaviourally through performativity. This complementary analysis of identity formation will allow for discussion of the dominant and alternative discourses at play in the negotiation of the subject-position of the birthing mother. Alongside this endeavour I will clearly position myself with respect to the data, exploring my learning through the lived experience of birth to deconstruct how my ways of knowing have developed over the course of this project. I will take guidance from the methodological framework of critical autobiography to practise reflexivity and produce

‘accountable knowledge’, allowing the reader of my project access to the contextually located reasoning that produced my project findings (Letherby 2002).

The philosophy of symbolic interactionism as interpreted by Mead (Morris 2015) and later Denzin (1992), highlights communication practices as the transfer vehicle for systems of ideology. Focusing on the communication component of interaction to develop the theoretical underpinning of my project, I enlist the analysis of the feminist theorist Kramarae (2005), who built upon the muted group theories of anthropologist Edwin Ardener (1975). These epistemologies will be held together by embodiment theory, to explore the features of how minded bodies and worlds fit together (Pitts-Taylor 2015). A discussion of data collection and ethical considerations of the project will follow the methodological presentation. I then justify my choice of narrative analysis, as described by Reissman (2008), as my data analysis tool. The three components of structural analysis, thematic analysis and dialogic analysis combine to formulate a rigorous and complementary framework. Within this chapter, these approaches are each justified and described in relation to their use in this project. Using three analytical tools adds robustness and depth to the analysis while overcoming the potential limitation of a small amount of data.

Chapter 4 presents the analysis of the 20 birth stories selected for this project and is divided into structural, thematic and dialogic sections. I used the structural analysis framework described by Labov and Waletzky (1967) as the first approach in the analysis of my data set. The relationship between meaning and action within the story through the function of different structural components, forms the basis of their theory. There are 6 component parts of their structure, named as; abstract, orientation, complicating action, evaluation, resolution and coda. Following this approach, I returned to my stories as if reading them for the first time to conduct a thematic analysis. This involved repeated searching across the data to find patterns of meaning that led to wider theorising and enabled construction of the data (Braun & Clarke 2006). The theoretical literature was accessed and revisited following construction of a thematic map from the data, resulting in further interpretation and refinement to present four interconnecting themes named as: (1) White Noise (2) Doing the body (3) Bargaining Authenticity and (4) Witness to Transition. Finally, I returned to the stories as a whole to conduct a dialogic analysis. Dialogic analysis proceeds from the assumption that a story is co-constructed with the real or perceived audience of the story but is also evidence of multiple voices speaking through the storyteller, heard through codes of language in borrowed words or phrases. Every story is built from the use of multiple intersecting speech communities, allowing the researcher to identify hidden discourses that tellers take for granted, and locate contesting voices in individual narratives. I take three exemplars from

the data set of this project to interrogate the dialogic spaces in complement to the results of the structural and thematic analyses.

Chapter 5 reminds the reader of the aim of the project and discusses the findings of the analysis under the methodological approach sub-headings. Within the structural analysis, the assumption of shared understandings of the core characteristics of different birthing models is apparent between the storyteller and their audience. The work of the story to perform control within the birth experience leads to either institutional resistance through a protest event in the narrative or dissatisfaction with the birth experience. The significance of this finding is discussed in relation to the wider vulnerability and resistance literature. The thematic analysis findings emphasise the dominance of cultural norms of autonomy and individualism that cause conflict within the storied experiences of birth. Experiences of vulnerability are discussed with reference to the admission of alternative modalities of being in labour. This finding highlights the presence of a discourse of resilience standing as a political opponent to vulnerability and resistance narratives. The stories of Alison, Sophie and Emma used in the dialogic analysis complement the structural and thematic findings to expose the systems of power and ideology shared through the communicative medium of the story. There is still a firm assumption among the storytellers that a natural birth is the ideal that all women must try to achieve, and this influences the co-constructive dynamic of the storytelling.

In Chapter 6 I bring the findings and discussion of all three analytical techniques together in a unifying discussion section. I offer an alternative perspective of vulnerability from the work of Butler (2016) that is supportive of embodied ways of being in birth. I also discuss how shared meanings could be evolved into a new shared language to expand the linguistic choice available for minded bodies to express their unique experiences of birth. The use of digital platforms to narrate the self and describe ways of ‘doing the body’ in birth, create and reinforce a community identity that has potential to mobilise for activism.

Chapter 7 advances the conclusion to my project question, based on the preceding presentation of evidence. I review the potential contributions and limitations of my project within the maternity field of evidence, followed by project recommendations.

Chapter 2 Literature review

As I stated in the introduction, this project is a study of birth stories and the work they do to position their storyteller within her experience of giving birth. Earlier work with birth stories has concentrated on identifying components of positive or negative birth experiences, perceptions of choice, shared decision making or compassionate care (Bylund 2005, Munro et al 2009, Hastings-Tolma et al 2018, Hirschenfang 2011, Kay et al 2017, Mosier 2016, umblin 2013, Weston 2011). The childbirth literature describes childbirth as a physical, psychological and socially transformative experience for women. Just as I had experienced personally, the literature emphasises how such a significant life event is associated with specific expectations from women, informed by numerous formal and informal sources. Fundamentally, there is the potential for dissatisfaction if these expectations are not met (Fisher et al 2006, Mozingo et al 2002). The literature suggests that the absence of one or more of the most commonly cited expectations can act as that source of dissatisfaction. In a synthesis of 229 studies addressing women's expectations for birth, Renfrew et al (2014) identified these as respectful and personalised care, availability of information for women to educate themselves and a trusting relationship with attending personnel. Other studies have cited remaining in control of their bodies during childbirth and experiencing participation in decision making (Ayers & Pickering 2003, Beaton & Gupton 1990, Fisher et al 2006, Melender 2002, Records & Wilson 2011). However, it is important to note that these expectations are often accompanied by a fear of the unknown among first time mothers. This fear can manifest as a need to remain within the safety of the 'system of birth', that involves handing trust to the medical and midwifery professionals to control the unknown, while retaining the assumption that these expectations will be fully facilitated (Ayers & Pickering 2003, Beaton & Gupton 1990, Fisher et al 2006, Kay et al 2017).

These expectations require delicate handling within the context of birth, as their achievement has the potential to stimulate feelings of positivity, empowerment, satisfaction and reduced anxiety in both the birthing experience (Anderson 2000, Fahy & Parratt 2006, Hirschenfang 2011, Kirkham 2000, Leap & Anderson 2004, McGrath & Kennell 2008, Mosier 2016, Sjogren 2000) and the woman's post-partum adjustment (Fahy & Parratt 2006, Stephens 2008). However, the absence of a combination of these factors has been linked to lasting distress (Soet et al 2003) such as persistent feelings of humiliation, social isolation (Forssen 2012) and failure as a mother (Beck 2011). The interpretation of the birth experience has the potential to impact upon the woman's future engagement with health services (Bowser & Hill 2010, DOH 2016, Pires et al 2002), their self-esteem (Kennedy et al 2003, Leap & Edwards

2006, Forssen 2012), bonding with their infant and adjustment to parenthood (DOH 2016, Fahy & Parrett 2006, Nicholls & Ayers 2007, Stephens 2008). Such consequences are rarely attributed to the childbirth experience as they tend to manifest after engagement with maternity services is complete, yet women still vividly recall the emotions and experiences of birth after decades have lapsed (Forssen 2012, Karlsdottir et al 2018). Such consequences emphasise the importance of post event reconstruction. Telling the story can be a way to name challenging feelings from an experience and make them easier to live with (Madsen 1994). The audience to this story, even if it is only the woman herself, becomes a witness to the reconstruction work contained within the story (Frank 2013). People often tell stories to work out their own changing identities, giving voice to an experience inadequately described through the dominant discourse and to guide others who will follow them.

In light of this detailed evidence, my project will take a different but complementary approach to previous achievements. I will cross the theoretical disciplines of midwifery, sociology and anthropology to make sense of the embodied selves in the narratives, to explore competing theoretical positions and how they contribute to the complex presentation of the narrators' experience. This eclectic view necessitates movement beyond the corpus concerning birth stories to review the literature on experience, memory, vulnerability and identity to successfully link together, and situate my project within, the matrix of influences shaping the birth narratives recruited for this project and ultimately the lives of the women narrating the story. In a climate of dissatisfaction with maternity services, rising awareness of the impact of negative experiences on future life activity and the potential healing role of story, there is a need for a cross disciplinary review of the evidence to expose new perspectives and insight within stories being told about birth.

2.1 Childbirth as an embodied experience

The foundation of my research question is the distinction between viewing childbirth as an experience rather than an event. The distinction in terminology between event and experience is important, because while an event may be an important or unusual occasion in one's life, an experience is something that leads to the participant gaining knowledge. Within the context of my project, I argue the knowledge derived to be embodied and to occur in a context of unique vulnerability. Denzin (1989) describes such a key moment as an epiphany. It leaves an enduring impression on one's life and the person is never quite the same afterwards. It can transform one's view of life and be relived within the individual's biography (Wainwright & Turner 2004), acting as a source of disruption in how people create meaning in their world (Becker 1997). The literature on the act of childbirth positions it firmly in this

experiential sphere, with the knowledge gained from such an experience being used to refine the individual's concept of self or personal identity (Morris 2015). Within this epistemology, Ellingson (2017) clarifies how people do their bodies, never in isolation, but mediated by continual interaction with others and the environment. The body is clearly a social phenomenon, engaging with others and exposing itself to others, making it vulnerable by definition (Butler 2009). Thus, while embodied experience is the product of a specific situation (Bordo 1993) it is crucial to both an individual's sense of self and how that self relates to and interacts with others (Wainwright & Turner 2004). This learning from the embodied sense of the material body and cultural rules and norms of discourse is brought together by Barad (2007) to create different situated 'becomings' rather than static meanings or essences of identity. In the same way, Deleuze (1988) describes the body as not fixed but in a fluid process of becoming, defined by its unpredictability and affective capabilities. Appreciation of this process of 'becoming', fed by the self-interpretation of the social world within which we move (Wainwright & Turner 2004), is essential to understand the importance and potential impact on the construction of identity of a woman's learning during childbirth.

How knowledge is gained during experience has caused fierce debate among scholars and emphasises the gender divide in society. Knowledge practices are full of cultural assumptions, and are the product of implicit agreement among a 'community of knowledge producers'. These are supported by claims about evidence and decisions made during investigations that culminate in a 'will to power' (Rose 1999). Within Western culture, the legacy of Descartes' philosophy dominates. It separates the higher order of the mind from the body. Within this view, embedded within medico-discursive knowledge, the body is situated as an object to be analysed and known. Consequently, the higher mind-self should seek to control its body-property and thus render it irrelevant to any knowledge project (Ehlers 2014, Ellingson 2017). This approach of the rational mind and objective knowledge production has been strongly associated with masculinity in our society with femininity linked to the reproductive body and emotional subjectivity. Grosz (1994) describes women as enmeshed in their corporeality. Positioning women within the unpredictable realm of nature, historically made a woman's attainment of rationality an impossibility. For some early feminists this meant supporting the dualism of mind and body, with the rational mind at the core of a contingent body, in an effort to gain entry to the closed world of education and scientific knowledge. For many feminists it has been essential to break these links between corporeal characteristics, social role and mental ability. Despite later feminist demands for the right of every woman to decide what should happen to her body, for example in the access to contraception and abortion movements of the 1960's, an implicit dualism remained

within the discipline, seeing the body as separate, as something over which the self had rights.

Beauvoir recognized,

“to be present in the world implies strictly that there exists a body which is at once a material thing in the world and a point of view towards the world” (Beauvoir 2015 p26).

This bodily existence and the point of view it provides, is lived differently for men and women (Grosz 1994), with extensive debate on the varying experience of bodies and how they are mediated by social positionality to constitute our sense of self (Alcoff 2005, Bordo 1993, Butler 1990, Grosz 1994, Irigaray 1993, Weiss 1999, Young 2005). Moi (2002) argues that it is the lived body rather than the social category of gender that is constitutive of the self. This is in contrast to Butler (1990) who emphasises the mapping of identities onto the body through continuous enactment or performativity of social norms. This perspective is developed by Young (2005) in her work on the restrictions of ‘doing the female body’ embedded within society that results in an inhibited intentionality. Rose (1999) shares this post-structural theoretical view, postulating the site of this discursive control to reside in the culture of liberal freedom that arose alongside the scientific discoveries in the body and development of the professions. He ascribes the thoughts, feelings and actions that appear to make up the intimate self of an individual as socially organized and managed by governing forces.

The discourse of rationality is perceived within society as the harbinger of control and predictability thus, the vulnerability of birthing women is emphasised by their entanglement with the material body and restricted access to different types of knowledge. Consequently, the activity of ‘doing the body’ has been marginalised by the objective way of knowing in modern medicine with ‘expertise’ invading the competence of the individual (Rose 1999). Self-awareness has thus become a private matter, through which we evaluate and regulate ourselves according to criteria provided by others (Rose 1999). Rather than trusting in the natural process of birth, trust is put in medico-juridical knowledge of experts (Ehlers 2014, Moll & Law 2004). Some of the women in the study by Chadwick & Foster (2013) described handing control for the management of the labour and birth to the medics, perceiving them to have more experience of childbirth. This acceptance and reliance upon the technocratic birthing discourse could reflect the cultural trauma of loss of women’s embodied birth knowledge. As mitigation of the vulnerability of the body has come to be seen as an individual responsibility or a ‘failure’ that must be addressed, technological treatment could be viewed as reasserting bodily control upon the birth process (Ehlers 2014). The intellectual

witness of birth through biological dissociation of epidural analgesia is described by Davis-Floyd (2003) as denial of the embodied conceptualisation of birth and introduces an increase in vulnerability through the treatment injury of the intervention (Ehlers 2014). Tronto (1993) argues this loss of embodied knowledge and experience of violence as surrender, illustrating a socially learned response to the paternalistic control of the institution and a gendered response to authority. She describes this as the political judgement of who should have authority over whom. I argue that it goes deeper than politics to expose an epistemological argument about the authority ascribed to different ways of knowing in our society. Furthermore, the demotion of birth by medical discourse to a routine (but potentially risky) event impacts expectations and experiences of women who seek knowledge, growth and relational connection, essential to the positive evolution of the self.

In contrast, experience of a natural birth has been described by Ryan et al (2011) as supportive of a pre-reflective embodied or emotional way of knowing, with thought and verbalization coming after the emotion has manifested itself in the physical body. This reflects an experiential dimension of knowledge based in the emotions. This pre-articulated or 'felt-sense' transcends the objective, integrating intuition as the body's participative way of knowing (Ryan et al 2011). Young (2005) describes embodiedness as liberating, empowering and agentic, reminding women of being a child and inhabiting a less problematic body. This can be extrapolated to inform reports of empowerment, agency and control among women who experience a mobile, active labour. Drichel (2013) would argue this to be an example of reframing the normative concept of vulnerability to that of a negative cap*ability,* opening the individual to the vastness and complexity of experience. This position destabilises the biomedical conceptualisation of the birthing body as solely a source of risk and potential dysfunction (Chadwick & Foster 2013). However, within our 'expert' controlled society, the instinctual and affective experiences of individuals become increasingly under the regulation of self-control, invested with feelings of shame that are internalized through the process of upbringing (Rose 1999). This can suppress the ability to interpret and act upon this knowledge. Thus, it can be intimated that women's birth vulnerability starts long before pregnancy, in the messages of birth culture and ways of knowing she internalises and brings to her own birth experience. Viewing childbirth as both embodied and an experience, rather than solely as a physical event, emphasises the impact of experience on a woman's enduring sense of self. It introduces the context of vulnerability, and supports the inclusion of different ways of knowing that are informed by material and cultural becoming within the lived body.

2.2 Vulnerability in childbirth

Vulnerability is rarely touched upon within the childbirth literature, yet if to live is to be vulnerable (Butler 2005) childbirth produces a particular modality of vulnerability. The work of Hogan hints at a unique vulnerability of birth by describing the context of birth as;

"the combination of a myriad of factors which renders childbirth and new motherhood as uniquely disorientating and potentially distressing" (Hogan 2017, pg53).

Exploring the literature on women's experiences of childbirth, to inform my classification of birth as an experience where learning has taken place, specific expectations from women for birth were revealed. They were informed by numerous formal and informal sources, with the potential for dissatisfaction if these expectations were not met (Fisher et al 2006, Mozingo et al 2002). Their interpretation has the potential to impact upon; the woman's future engagement with health services (Bowser & Hill 2010, Pires et al 2002), her self-esteem (Forssen 2012, Kennedy et al 2003, Leap & Edwards 2006), bonding with her infant and adjustment to parenthood (Fahy & Parrett 2006, Nicholls & Ayers 2007, Stephens 2008). Core concepts identified by birthing mothers as necessary for a positive birth experience, included respectful care, trusting relationship, control, and participation in decision-making (Ayers & Pickering 2005, Beaton & Gupton 1990, Downe et al 2018, Fisher et al 2006, Karlsdottir et al 2018, Melender 2002, Records & Wilson 2011, Renfrew et al 2014). The experience of such concepts was often associated with positivity, empowerment, satisfaction and reduced anxiety in both the birthing experience (Anderson 2000, Fahy & Parratt 2006, Kirkham 2000, Leap & Anderson 2004, McGrath & Kennell 2008, Sjogren 2000) and the woman's post-partum adjustment (Fahy & Parratt 2006, Stephens 2008). The absence of a combination of these factors has been linked to lasting distress (Soet et al 2003) manifesting as persistent feelings of humiliation, social isolation (Forssen 2012) or failure as a mother (Beck 2011). Such consequences are rarely attributed to the childbirth experience as they manifest after engagement with maternity services is complete, yet women still vividly recall the emotions and experiences of birth after decades have lapsed (Bossano et al 2017, Forssen 2012).

These expectations reveal a particular conceptualization of health and modes of embodiment by which vulnerability is measured in healthcare, through the expressed desires of these birthing women that will afford them protection. Measurement of the enduring consequences of women's defence against vulnerability further emphasised the importance of vulnerability to the experience of childbirth in my project (Butler 2005, Martin et al 2014). While there is general agreement in the discourse that by the very nature of being human,

we are vulnerable (Butler 2005, Cavarero 2009, Diprose 2013, Kemp 2000), there is divergence in the interpretation of its manifestation. The normative definition of vulnerability rises from the Latin root of the word: *vulnus*, which means wound (Drichel 2013). Vulnerability thus emerges as a threat, as an exposure to wounding or the possibility of harm as a result of specific circumstances (Harrosh 2012). Vulnerability is defined in the Oxford dictionary as:

"Exposed to the possibility of being attacked or harmed, either physically or emotionally" (Oxford online dictionary 21/11/16).

Consequently, the response to vulnerability aims to create closure and boundaries against the threat, restoring a sense of control over the threatening environment. Maintaining control featured widely in the literature review of women's expectations for birth, illustrating interpretation of vulnerability as the threat of harm. If being vulnerable is to be at risk of harm and being perceived as weak, then to be competent and strong is to be invulnerable (Gilson 2011). This positions vulnerability as the problem that Gilson contests, as she sees vulnerability as a condition that can also enable us (Gilson 2011, Shildrick 2002). While both viewpoints acknowledge shared vulnerability as a characteristic of being human, the Institution of 'expertise' or medico-juridical system governing childbirth assumes an ability to quantify physical indicators of vulnerability, encouraging top down solutions and paternalism. Critics of this approach label the essentialising classification of 'the vulnerable' and application of protective measures to be a form of violence itself (Diprose 2013).

The principal perspective on human vulnerability within medical bioethics is guided by the declaration of Human Rights (Martin et al 2014). The Universal Declaration on Bioethics and Human Rights of 2005 (UNESCO 2005) emphasises in Article 8 the need to take into account the global condition of the human as vulnerable when considering advances of medical technology. It continues by expanding its definition of vulnerability to include individuals and groups of special vulnerability that require protection and respect of their integrity. According to Foucault's work on disciplinary and biopower (2008), a 'right' is a discursive construction that invokes a fixed picture of identity. Appropriating the rights discourse can stimulate collective political action by rejecting the individuality of our neoliberal society (McNay 2009). Martin et al (2014) operationalise this human rights message by defining 3 moments to support assessment of an individual's vulnerability. These moments are: the reason an individual is vulnerable; the context under which vulnerability may manifest; and finally, the actual manifestation of vulnerability. The reason an individual is vulnerable is what Martin et al (2014) refer to as the interests of welfare. For

example, within a childbirth context, this could refer to a desire for caesarean section because of a traumatic first birth, thus the woman is vulnerable if she presents in labour and her request is not considered. A converse example might be a birthing woman's desire for a natural birth with as little intervention as possible due to a fear of encroaching medical intervention and its complications. If she is supported by a midwife who believes in the medical model of birth, the birthing woman is vulnerable to psychological and medical messages that may question her competence, and is physically vulnerable as a result of the checks and measurements of medical protocols that can easily disrupt the rhythm of her labour.

Another reason to ascribe vulnerability using the framework of Martin et al (2014) originates from issues concerning agency. These are values, goals and principles arising from the individual that they wish to protect and that are enacted in their freedom of choice (Martin et al 2014). The frustration of agency can easily impact upon interests of welfare, for example being treated with disrespect may cause serious mental distress. Butler's work (2005) reframes this reductionist bioethical approach to the concept of vulnerability, instead making it the basis for an ethics of non-violence based on corporeal interdependence. She declares the relation between the 'I' and the 'you' to bring the 'I' into existence, and by the reaction to the example of disrespect, to undo it. Thus the 'I' is actually a composition of its matrix of entanglements with others without which it would not survive. Desiring care and receiving something else naturally causes the 'I' to feel exposed and to try to defend itself against the vulnerability. This may include the destructive act of cutting oneself off from its relationality, without which there is no self. Consequently, this defence against vulnerability perpetuates the very violence from which we seek protection (Butler 2005). Drichel (2013) recommends slowing down in the scene of vulnerability and learning to remain within vulnerability's uncomfortable space. By allowing a little uncertainty, attention can be drawn to the potential of vulnerability to open us to being affected and affecting in turn, though we will not know if the end result will be satisfaction or frustration (Gilson 2011). At least this offers a chance to contemplate alternative iterations of vulnerability emerging alongside the rhetoric associating vulnerability with a likelihood of violence.

Martin et al's (2014) second moment to ascribe vulnerability is in the context that can result in vulnerability. These authors acknowledge this context as created in interaction between an individual and the world. Butler (2005) describes how we are vulnerable to losing the connections and support of our precarious interdependence. She describes it as pre-reflective as we often get by without realising it until it is missing. On a macro level, Oliviero (2016) classifies vulnerability as a socio-political creation since someone or something is responsible for the threat or harm. She emphasises the interaction between an individual

and institutions to result in structural conditions that generate vulnerability. This perspective is shared among trans-national feminists who expose the link between systemic disparities and identity-based modes of representation to explain the experience of such structural vulnerabilities among certain communities (Hesford & Lewis 2016). As a part of this school of thought that crosses traditional community and state boundaries, Oliviera (2016) discusses how identity is one of the sites through which vulnerability is both experienced and perpetuated. However, identity can be used as an asset to mitigate against vulnerability as it leads to recognition of a community and opportunities for collective voice.

Vulnerability is context dependent as its experience may change as circumstances evolve in the allocations of power and resources that create the inequalities (Oliviera 2016, Smith et al 2010). This contextual interpretation fits with the modality of childbirth as the birthing woman becomes 'circumstantially dependent upon' the midwife or medical team (Walker 1988). She becomes temporarily dependent on others during the labour and childbirth component of the pregnancy as she enters a powerful, largely unknown, transitional event. Physically she transitions from a state of pregnancy to separation of the fetus from her body. Socially she transitions into the category of mother. Transitional experiences expose the individual to the possibility of harm as they travel between social categories (Geertz 1973).

The last of Martin et al's (2014) moments assesses the manifestation of vulnerability in support of UNESCO's Article 8 that classifies certain individuals or groups as more vulnerable than others. These are summarised to include those unable to protect their own interests, more likely to be exploited, lacking in basic rights, or at risk of unequal opportunity to achieve their full health potential and quality of life. These reasons are actually manifestations of the characteristic of vulnerability intrinsic to all individuals. They have been credited to unequal distributions of power and effects of institutional structure and representation on the lives of individuals (Oliviera 2016). Martin et al (2014) brings this to an individual level using the language of welfare and agency interests. Drawing on the responsibility ethics of Levinas, they describe how if someone else has the power to either fulfil or deny the achievement of these interests, then they have a responsibility to take them into consideration. This ethic calls for vigilance against any aggression that the fragility of the other may provoke (Diprose 2013). The biomedical perspective would be to apply additional protective measures to ensure they receive what is due to everyone. In contrast, scholars viewing vulnerability as negative cap*ability*, describe an experience of vulnerability as a disruption in identity and power relations that calls us into an ethical relation of responsibility for the vulnerability of others (Ziarek 2013).

Martin et al (2014) argue vulnerability is not the source of moral obligation rather it is a reason why we need morality to guide our treatment of others. They describe vulnerability as an action-guiding concept, existing because we have both welfare and agency interests that may be thwarted. They position the moral importance of these interests above the concept of vulnerability itself as the source of moral obligation. In contrast, Butler (2014) argues for a deconstruction of the relationship between vulnerability and agency that fuses vulnerability with a context of harm or injury. She calls for attention to how vulnerability can be activated as a political tool of advocacy and movement by exploring how it is used by 'differently positioned bodies' to perform resistance. It has been shown on a community level that engaging those experiencing temporary vulnerability due to a pandemic or natural disaster can empower members, increase trust in decision makers and ultimately reduce the situational vulnerability and associated compromise in welfare or agency interests (Smith et al 2010). When birthing women feel included in decision making, their perception of trust in the health worker to promote their interests increases and often results in reports of empowerment from the birthing woman (Downe et al 2018).

2.2.1 Birth as a rite of passage

A rite of passage is described within an anthropological context by Geertz (1973) to have 3 components; a rite of separation, a liminal period, and a rite of incorporation. The individual will undergo social change, symbolically facilitated by separation from their old environment. Within a childbirth context, this separation could be attendance at hospital or birth centre in labour, or preparation of the home for birth. Rites of cleansing and purification often occur with the wearing of new clothing. For example, bathing and toileting in the early stages of labour, changing in to hospital gowns or loose clothing in preparation for the need to allow access to the woman's anatomy for monitoring of the progress of labour, health of the fetus, skin to skin and breast-feeding post birth.

The middle stage is called the liminal period and is characterised by those undergoing the rite as having no status. This is because they have left their old role but have not yet gained their new role. Working on the premise that the self is constituted by a continual process of social interchange, this experience leaves one extremely vulnerable due to the interpretation of personal status during the experience and the openness to learning of the birthing woman about her new role in society (Morris 2015, Seel 1986). This learning is commonly achieved through the experience and interpretation of birthing rituals in conjunction with internalized expectations of labour and birth and can be seen as a form of subjection to the power of discourse (McNay 2009). Rituals can be described as technologies of the institution. They

express social values and affect the individuals involved through internalisation of the messages (Foucault 2008). Individuals may be subjected to humiliation, discipline and pain with symbolic instruction about the nature of society and what is expected of them. Within a birth context, humiliation may encompass experiences of exposure as the woman is subjected to a medical view of her body. Discipline, or control by the institution, may also be internalized by the woman through the perception of her socially situated behaviour during labour and birth and the perception of institutional rules imposed upon her, with pain a core component of the birth experience.

This bodily experience is contained within an interpretive context formed by internalized expectations of the labour experience that Davis-Floyd (2003) names the belief model, emphasising the diffusion of the mind through the body or the body-mind system (Ellingson 2017). This sensitivity exposes a context specific vulnerability in the woman, unique to the childbirth event that is initiated by the contingency of the body (Frank 2013). The interpretation of this vulnerability as unique to the childbirth event does not mean to present an essentialist approach. Instead the term is used to describe a collection of events converging within one time-space to create opportunities for the potential exposure of the self and the body to the possibility of harm (Hogan 2017). Butler (2005) emphasises an interpretation of harm may not be easily measured by an outsider through physical characteristics, and so she positions vulnerability as a singular irreducible experience. Despite this singularity, Mead (Morris 2015) acknowledges that there are components of experience shared by all that can be used as a starting point to interpret what is specific to the individual's experience. Within a childbirth context, the dominant birthing model may prioritise different components within the birth journey to the expectations contained within the woman's birth belief model. Consequently, this may be perceived as a threat by the labouring woman. Such potentially disrupting stressors explored in the childbirth literature are multi-level and include environmental composition (Fahy & Parrat 2006), intractable pain (Van der Gucht & Lewis 2015), and factors underpinned by the concept of exposure (Goffman 1959).

A period of waiting before the end of the liminal stage is common and could signify the 10 day midwifery support before discharge from institutional supervision. The final part of the rite of passage, the rite of incorporation, moves the subject back into the world in their new role with public announcement and celebrating. Davis Floyd describes this reintegration to often be missing and therefore a contributor to women's sense of turbulence post birth (Davis-Floyd 2003). Within a theoretical context, Mead (Morris 2015) described the existence of meaning to be based upon the relation of the gesture or act of one person to

the adjustive response made to it by another. Since the meaning of the act or gesture is the response of the other to that gesture or act, a lack of acknowledgement from the wider social community of the achievement within birth could be internalised and potentially in contradiction to the woman's expectation.

2.2.2 Exposure and its link to birth vulnerability

To situate the findings from this anthropological lens within the wider theoretical literature, underlying sociological explanations were explored that link to historical controls in social position and behaviour of women in society. The liminal experience of birth, where women are sensitive to symbolic messages about the nature of society and what is expected of them, offers an opportunity for the historical vulnerabilities of exposure, unpredictability, and inadequacy to impact the woman's interpretation of her birth experience. Exposure of culturally intimate symbols related to concepts of hygiene and the moral condition outside of the private space can reinforce a sense of vulnerability in the woman as the usual social order is disrupted. Examples include the exposure of the woman's nakedness, genitalia, defecation and blood. Culturally appropriate management of these artefacts during birth take place to remove the sexuality and intimacy from birth and thus the potential stigmatising shame of exposure (Davis Floyd 2003). This is as much to protect the vulnerability of the birth worker exposed to an intimate experience over which they attempt to have jurisdiction, as that of the birthing woman sharing an intimate experience for which she is seeking support (Davis-Floyd 2003).

The potentially stigmatizing shame of exposure can be traced back to the Victorian era in England where social stability was seen by the middle classes to be dependent on moral purity in a changing world of industrialisation and population control. The Victorian obsession with sexuality provided a framework for control of the working classes under the guise of morality rather than addressing the more complicated structural issues of class conflict (Skeggs 1997). This shifted moral responsibility to the family and the role of the mother to control and discipline themselves and their husbands and sons. Sexuality also moved into the privacy of the home, with the locus as a fertile one in the marital bed. Proper demeanour of the time valued modesty, avoiding contact with other bodies and with verbal decency sanitizing speech (Foucault 1978). Areas of tact and decency became socially defined, while personal self-control, perseverance and occupation became characteristic of moral citizens (German 1989). Subjects are therefore constituted by the discourse of culture with performativity of these behavioural norms acting as the regulatory regime of morality (Butler 1999).

The impact of the social attitude of power and control alluded to by Martin et al (2013) is grounded in the work of Foucault (2008) who explores the flow of power and the different modes by which human beings are made subjects. It is deconstructed in the birth territory study by Fahy & Parratt (2006). They proposed the configuration of the hospital birthing room to emphasise a woman's physical exposure in its surveillant design. This design typically includes bright lights for birth workers to see, free access to the room by institutional personnel, with the bed and bed confining monitor in the centre of the room. This design facilitates exposure of the body as an object through observation and monitoring, alongside a restriction of agency by physical confinement and removal of labour interpretation from the woman to the monitor. The negative impact of what the authors term 'disciplinary power' on the emotional wellbeing and physiological experience of the woman in labour is explored. Examples of disciplinary versus nurturant power dynamics in the interactions with birth workers emphasise the woman's emotional sensitivity and the potential restrictive or enhancing impact of these dynamics on the experience of labour (Beckett 2011). These findings are reflected in the reports of violation among the mothers of Forssen's (2012) work. These reports were more likely in relations of power imbalance, characterised by objectification, indifference, condescension and dismissal. Consequences among the women were shock, fear, disbelief, anger, pain and embarrassment. The treatment of the body as a surface among young women in a non-childbirth study by Del Busso & Reavey (2011), also created a feeling of disempowerment. This is in contrast to the participants usual ability to experience themselves as embodied agents in the world.

During the liminal state of birth, the body and mind can become overwhelmed as events occur in excess of current frames of reference (Frank 2013). Seel (1986) describes the heightened suggestibility accompanying the overwhelming emotional stimulus of labour as psychological anchors are sought. It is in this stage that an individual can be effectively conditioned to their place in society. Since the liminal state opens one up to the potential of their vulnerability, there is a unique opportunity for the transformation of one's identity through either empowerment or cultural entrainment (Diprose 2013, Gilson 2011). A process of cultural entrainment has occurred when reality as presented by obstetric procedures, and the birthing woman's perception of reality become the same. This fusion reinforces belief in the value system sustaining the position of technological birthing (Davis-Floyd 2003). Within the technocratic model of birth, this can reinforce a low status view of the woman versus the child and women's knowledge against the power of science, reinforcing subordination in the social structure. The more birth is taken over by the technocratic model, the more likely the mother's behaviour will be affected by external and social cues (Dahlen 2010), considered essential for a safe outcome, rather than the internal ones of her own body (Kitzinger 1978).

Thus, a crisis in the self has been reported in the childbirth literature, not necessarily from the use of technology itself, but from the implications of its use, challenging agency, control and the woman's belief model of birth (Seel 1986, Walsh 2010).

The participants of Davis-Floyd's (2003) research described the presence of a conceptually congruent birthing partner (partner, family member, birth worker) as a significant buffer to prevent fusion between the woman's belief model and the technocratic approach of the institution. This is based on the belief that individuals are socially embedded, where social relations constitute an individual's identity and this is reaffirmed or discredited through interaction with others (Baumeister & Leary 1995, Butler 2005, Morris 2015). Within the unknown and challenging birth environment, women are vulnerable to their own and the perception of others' expectations of how they should behave. While the findings of Fisher et al (2005) emphasised the woman's sense of self as the most influential factor on her birth experience, Jacobsen (2009) emphasises the effect of others on the dignity of the self. Frank (2013) describes the communication between bodies as a sense of alignment. He describes such bodily messages as transcending the verbal, conveyed through touch, verbal tone, facial expression and gestural attitude. When bodies are in alignment, words make sense in the context of that alignment. When that alignment is lacking, even the best content risks misinterpretation or will be unsatisfactory as a message.

This observation underlines the significance of a need for safety from psychological exposure to an incongruent birthing discourse, or safety from the physical exposure of culturally intimate symbols and behaviours to contribute to an enabling birth space. In this environment a woman is more likely to feel safe to 'let go' of her need to perform certain behaviours and allow her body-in-labour precedence to control the birthing of her baby (Akrich & Pasveer 2004, Anderson 2000, Kirkham 2000, Leap & Anderson 2004). Experience of a safe birthing environment has been found to impact upon the ability to cope during labour, the experience of shorter labours, less augmentation, fewer interventional deliveries, more bonding behaviour between mother and baby and improved postnatal outcomes (Ayers & Pickering 2001, Baker 2010, Downe et al 2007, Gibbins & Thomson 2001, Hodnett et al 2002, Hardin & Buckner 2004, John & Parsons 2006, Kennedy et al 2004, Klein et al 2006, Martin et al 2013, McGrath & Kennel 2008, Proctor 1998, Reed et al 2017, Renfrew et al 2014, Sydsjo et al 2015, Van der Gucht & Lewis 2015).

2.2.3 The body in birth

Childbirth is an intensely physical and psychological experience as physiological sensations foreground in one's perception, abating only after the birth of the child. The birthing mother is

subject to an in suppressible physiological cascade that has proved vulnerable to disruption from internal and external stressors. During labour the hormone oxytocin is released in pulses from the pituitary gland in the brain and locally from the reproductive tissues to promote contractions in the uterus through a variety of hormonally mediated positive feedback cycles. While maintaining progress in labour, oxytocin has also been found to stimulate endogenous analgesic release in the brain, to reduce stress and fear in the labouring woman, stimulate the 'let down' reflex for the commencement of breastfeeding post-partum and to significantly impact bonding behaviour with the baby. In contrast, excessive stress in labour has been found in animal studies to disrupt oxytocin release and inhibit contractions, possibly because of adrenaline/nor-adrenaline elevations (Buckley 2015, Lederman et al 1978, Simkin 1986). Observational studies in humans suggest the elevation of adrenaline/nor-adrenaline may be stimulated by a perceived threat to the labouring body (Buckley 2015).

Such intense physicality, in the majority of cases, is not pathological, yet the cultural construction of pain as suffering in our society is transposed onto childbirth and appears to conflict with the promotion of non-technocratic birthing (Moore 2016). As one respondent commented in the paper by Savage,

"Childbirth is the only major medical procedure involving so much pain and you are expected not to have anything" (Savage 2006 pg16).

This neatly reflects the embedded pathologizing of labour as a medical procedure, the introduction of risk and the associated experience of pain as suffering. Fundamentally the discipline of obstetrics employed in hospital birth is a surgical speciality thus women are turned into patients and the female body into a public space and unit of management (Rothman 2014). The risk of the body malfunctioning during birth is described by Davis-Floyd (2003) as the foundation of obstetrics and sows doubt in the collective consciousness of women's ability to endure without medical intervention (Scamell 2011). Simkin (1996) blames the dependence on experts for childbirth knowledge on the increasing mobility of people within modern society, as fewer women learn about pregnancy and childbirth from traditional sources of mothers and female relatives. Diprose (2013) emphasises the experience of vulnerability in a paradigm of risk as reducing human vulnerability to passivity, undermining agency and justifying takeover by a totalitarian power – be it government or medical institution.

However, as the dominant childbirth care model of the UK is located within the medical discourse of risk, viewing the unpredictability of birth as normal only in retrospect, safety is privileged over lived experience (Walsh 2010). The historical promotion of medical

supervision and hospital birthing in the UK as the ‘safest’ way to birth has become culturally embedded and reinforced in our society to reflect the expected arrangement for birth (Liaschenko 2006, Hyde & Roche-Reid 2004, Moore 2016). This focus on safety by modern obstetrics has been described as child centred (Seel 1986), implying an appropriateness of women’s suffering to benefit the child. This can be experienced through certain birth model rituals that deny the importance of the mother’s feelings during labour, reflecting the loss of status characteristic of the liminal period. Rituals can suggest that if she wants to be a good mother, she must subordinate her own needs and desires to those of her baby.

The regulation of nature, embodied by the pregnant woman, through the imposition of technocratic knowledge reflects the wider structural inequality between women’s knowledge of birth and the state sponsored deployment of expertise (Foucault 2008, Lawler 2014, Rose 1999). Simkin (1996) interprets reliance on medical intervention as a loss of women’s personal experience, knowledge and self confidence in birth. However, Klein et al (2006) describes women’s knowledge as less applicable to this new experience, resulting in reliance on experts to provide education in the new rules for birth. The social superiority of medical knowledge is therefore consigning women’s birthing knowledge to the realm of ‘old wives’ tales’ and superstitions. Slovic et al (2005) describe how as humans we have evolved to gain more control over our environment. This development has involved the invention of analytical tools to inflate the rationality of experimental thinking, while affect (or emotion) is dismissed as interfering with reason. Reed et al (2017) surveyed 748 women about experiences of birth trauma to find a disregard of embodied knowledge in favour of care provider’s standardised clinical evaluations a frequent source of distress. Such supervision and measurement rituals can also result in women losing confidence that they can give birth without medical assistance, losing trust in their bodies (Kitzinger 1978), making dependence on others, instead of the self, a condition of motherhood (Oakley 1986).

Del Busso & Reavey (2011) describe the material body as a formative aspect of people’s sense of self as feelings and bodily sensations help to interpret experiences that inform one’s concept of identity. The body acts as a reservoir for and a generator of memories. This is significant as the memory of the self is our source of information about our lives from where we make judgements about our own personality and behaviour, as well as that of others (Misztal 2003). A lengthy process of cognitive restructuring is described as necessary to then align the woman’s behaviour in the reality of birth with her self-perception prenatally (Seel 1986). This is in contrast to the counter discourse of home birth where the unpredictability of the body is accepted, and the woman dwells within the vulnerability of her birth to remain open to emotion and affect, often resulting in positive and powerful feelings for herself and her companions (Diprose 2013). Within this approach women birth within

their social context, retaining maximum levels of control and opening the arena to other ways of knowing (Savage 2006). This birth model commonly reflects the search for cognitive anchors through alternative bodily dissociation such as breathing techniques, mobility and mindfulness (Akrich & Pasveer 2004). This approach works with the unpredictable body as opposed to attempting to impose predictability upon it through measurement and surveillance rituals.

2.2.3.1 Inadequacy

From within the origins of medicine, the female body has been described as inherently defective and dangerously under the influence of nature, which due to its unpredictability is in need of constant manipulation by men (Davis-Floyd 2003, Diprose 2013). Respectability of women thus became linked to a complex matrix of representations of appropriate and acceptable behaviour through advice giving 'norms' and manipulation of consciousness (Skeggs 1997). Historically, deviance from such a moral condition among women confirmed their weakness and held serious consequences for external control of their person (Showalter 1985). Choi (2000) describes how social learning can encourage restrictive and less mobile body styles among women. This can manifest as the perception that one is gazed upon and treated as a performance of a groomed and relatively static body object of another's intentions or manipulations rather than as a living manifestation of action and intention. This view suggests physical capability is often constructed as 'masculine' and antithetical to femininity. Within maternity care, women have described themselves as being made to feel no more than a vehicle for human reproduction (Cook et al 1999, Davis-Floyd 2003, Hyde & Roche-Reid 2004, Kennedy et al 2003, Kitzinger 2015, MacLellan et al 2015). This process of body – self fragmentation can remove a woman's sense of being in the world as a complete subject to a sense of being made up of a surface of body parts which don't cohere into a unified whole (Gill 2006). This can lead to a struggle for women to experience themselves as the rightful occupier of their bodies, with a loss of self and perceived ability to act upon the world (Del Busso & Reavey 2011, Diprose 2013). When this corporeal control or embodied agency was missing, the participants in the study by Reed et al associated it with a sense of violation,

"not having the right to do with my body what I wished" (Reed et al 2017 p32)

and starkly reflects the loss of status witnessed in the liminal stage of anthropological rites of passage (Geertz 1973). The resulting negative experience can contribute to a feeling of alienation, negating agency and leaving the woman in a position of extreme vulnerability until she can ground herself again with some meaningful embodied subjectivity or implement

protective behaviours (Brown 2010, Walsh 2010). The social control of women's behaviour and sexuality is a discussion of its own but holds relevance to this topic due to the subliminal impact of such discourse on women's expectations and experiences of a particular modality of vulnerability in childbirth (Shilling 2016).

As childbirth is an interruption in the productive role of our post-industrial society, women are under pressure to perform well and many expectant mothers wish to show their independence and ability to cope without seeking help (Kitzinger 1978). The dynamic nature of mothering and unpredictability of pregnancy and birth emphasise the role of planning and control (Kitzinger 1978). Frank (2013) describes how people frequently define themselves in terms of their body's varying capacity for control. Frank (2013) describes contingency of the body within the context of illness as disrupting a stable state of being, that cannot be controlled and carries an absence of certainty. Childbirth shares these core characteristics of disruption of the stable state, and an inability to be controlled with an absence of certainty. Both contingencies can cause further loss, such as the control of body fluids and loss of comfort in the experience of pain. Frank (2013) illustrates how some people can easily adapt to these contingencies, while others may experience a crisis of control. Loss of control is stigmatising, for both those experiencing and witnessing the loss.

The obligation of constant control of that doing body implies the threat of failure (Moll & Law 2004). This can leave the birthing body vulnerable to a perceived crisis of control and thus the self is exposed as vulnerable (Chadwick & Foster 2013, Frank 2013, Jacobsen 2009). Such a situation of crisis and vulnerability is classic of the liminal period of transition as the predictability of learned versions of reality and previously successful responses are no longer effective. At this stage, individuals will look for other ways to structure their experience or make sense of their current reality. Rituals can stabilise an individual under stress by acting as a cognitive anchor. They can mediate between cognition and chaos by making reality appear to conform to accepted cognitive categories. When adult bodies lose control, Frank (2013) describes the social expectation that they regain it and if this is not possible, to conceal the loss as effectively as possible. Obstetric rituals and routines can fit the birth process into such masking categories, making the unpredictability of birth happen in an orderly way, and so provide cognitive anchors for the woman and her attendants (Davis-Floyd 2003).

Denial of the capability of the body in a society that operates on the premise of order and control can impact women's ability and courage to listen to their bodies (Martin et al 2013), and by moving the private act of birth to the public arena reinforces the public performance of expected behaviour (Davis-Floyd 2003). Within this context, the momentum of the

institution has been described as propelling women into interventions by the appropriation of rituals to stabilise an individual in a time of stress (Newnham et al 2017). This appropriation is classically reflected in the assumption of culturally rooted behaviours stimulated by entry into the institution, redolent of Parson's sociological description of the 'sick role' (Parson 1951). Parson's sick role (1951) articulates the requirement that the ill person (read birthing woman in the hospital) delegates responsibility for their health to the physicians, obligating narrative surrender. Identity is relinquished and one becomes a patient in their hospital. Illness responsibility is therefore reduced to patient compliance. Examples from a childbirth context include acceptance of the cannulation of women in labour or frequent vaginal examination to check labour progress. However, coercion to participate in this model of care is not required as authority is given to the technical practitioners through recognition of what knowledge and skills they offer by the very women asked to subject themselves (Arendt 1970). Technocratic interventions during birth have been described as making women feel powerful over the restrictions experienced by nature and as full participants in the higher order of culture (Davis-Floyd 2003). This creates a symbiotic relationship of women's need and the maintenance of professional actuality.

Fear of pain is a significant concern of pregnant women regarding labour (Fenwick et al 2009, Schytt et al 2008). Fear of pain in labour is suggested to be a manifestation of the deeper anxiety about losing control during the experience of pain resulting in a sense of inadequacy (Leap et al 2010). The presentation of self carries a significant influence upon the prioritising of control in labour as found in Geissbuehler and Eberhard's (2002) study of more than 8000 pregnant women. They found women to be afraid of losing control during labour and behaving inappropriately. Loss of control is described by Goffman as stigmatizing (Goffman 1963). An adult must avoid embarrassing themselves by being out of control in situations where control is expected. Furthermore, women in labour are expected to avoid embarrassing others who may be a witness to their lack of control. This is because we are responsible for how we present ourselves. An obstetric surgeon from 1847 declared pain as neutralizing the sexual emotions therefore ether should not be offered as it alters the modesty and emotional self-control proper to the female sex (Davis Floyd 2003). While representing an extreme and outdated view, the underlying historical source of women's control of their behaviour and bodies is neatly illustrated.

Madsen (1994) describes pain free birthing as the ultimate denial as birth pain exists for a reason, marking the physical and emotional transformation of birth. It has been found by Van der Gucht & Lewis (2015) that an acceptance of pain during childbirth enhances the woman's ability to cope with that pain and maintain internal control of her response to labour. Expectations of medical intervention accompanying birth are especially linked to the

provision of pain control in the study by Schytt & Waldenstrom (2010). In a comparison of delivery units across different regions of Sweden, they found the local cultural practice of the delivery unit to significantly influence the proportion of women taking up the option of epidural analgesia in labour. Simkin (1996) describes women as contributors to this rise of technocratic birth in their post war consumerist demands for pain free birthing. Those physicians not offering the 'twilight sleep' drugs were labelled as sadistic and 'anti woman', as pain was equated with danger and risk. This directly reflects the rise of the medical institution in society and their public declaration that birth can be controlled, removing some of the inherent fear of the capacity of the body evident during childbirth (Davis-Floyd 2003).

A respondent in the research of Madsen (1994) described her fear of the physicality of birth and 'what is required of me', implying a fear of nature and of her performative inadequacy. However, the fear of not meeting those expectations, of feeling inadequate can prompt a shame response. Brown (2010) describes such a response as withdrawing or keeping silent; seeking to appease or please; or being aggressive or blaming. All of these behaviours are evident in the analysis of this project. She describes shame as the fear of not being worthy. Some women are documented in the literature as feeling scared and can feel useless because they are scared (Nilsson & Lundgren 2009). This sense of inadequacy is exacerbated by the essentialising normal birth movement in its political stance against the medical colonisation of childbirth (Walsh 2010). It emphasises the birthing mother calmly breathing through her contractions in control of her response to the pain of birth (Carson et al 2016). The agony and suffering are not told, impacting women's expectations of childbirth and their psychological preparation for it.

However, Brown's research has shown the transformative power of story, where those who owned and shared their stories practised shame resilience. The exponential rise in the public sharing of birth narratives across the internet, from positive empowering examples in personal blogs and testimonies to negative horror stories on mum's chat rooms, may be one opportunity to exercise resistance to the social subjectification of the woman in the territory of the everyday (Rose 1999). It may also offer an opportunity to perform the desired identity of autonomy and control within the birth journey and legitimate entry into the 'mother's club' that exists in oppositional support to the medical birthing discourse. In contrast, telling one's own birth story could be described as a form of meta-control as the social prescription of keeping the compromised identity of loss of control hidden is transcended (Frank 2013). The becoming mothers of Davis-Floyd's (2003) research described powerful physiological and cognitive transformations during birth with a very real need for social acknowledgement and cultural alignment to give meaning and order to an often chaotic and bewildering experience. Perhaps the explosion of birth stories through the impersonal medium of the internet is one

route to finding that social acknowledgement of transformation and personal meaning in birth (Zwelling 2000) while attempting to self-fulfil a missing rite of incorporation.

2.3 Storytelling and birth

The story has been described as the most fundamental unit to account for the content of lived experience (Clandinin & Rosiek 2007). This claim originates from an understanding of lived and told stories as a portal through which an individual enters, interprets and creates personal meaning of the world (Clandinin & Rosiek 2007). The work of meaning making is foregrounded in liminal circumstances (Wieder & Zimmerman 1974), so it follows that birth narratives have been found to provide women with the most accessible and often utilized means for giving voice to their exploration of meaning in their births (Davis-Floyd 2003). Stories act as a mirror to the social, cultural and institutional narratives, within which the individual's experience is shaped, enacted and expressed (Gubrium &Holstein 2009), while the self, or an aspect of it, comes to be through the process of storytelling (Cavarero 2000, Ricoeur 1984). Frank (2013) describes selves as perpetually recreated within stories while Barad (2007) would describe this as evidence of identity as a situated becoming rather than a static state.

Bodies are described by Frank (2013) as giving shape and direction to stories, setting in motion a need for new stories when disease disrupts the old story as there may be difficulty in continuing to be the same body as before the event. In this light, the stories women tell of their birth come out of their pre and post experience bodies. Stories can be used to make meaning out of the intersection of identities with the social world, providing shape to our lives so that we feel like we have meant something. Cavarero (2000) describes narrative exchange to originate from fear, that a life led in the absence of a public space of exhibition, leaves no life story and by consequence, no identity or existence. Thus, a political space is created for reciprocal exhibition. All attempts to produce knowledge are political (Krook 2007), which makes narration intrinsically political as people choose which stories to tell (Kleinman 2013).

Illness stories have been described as repairing the damage done to the individual's sense of self by the illness or to restore an order the interruption of illness has fragmented (Frank 2013). This self story is told to others and to one's self, enclosing one story within another, as such, listening to a woman's birth story can offer insight into her belief model and experience of transition to motherhood. Frank (2013) describes the need to tell stories as an individual's attempt to reclaim their experience from the unifying view of the medical

narrative. He describes medicine's colonization of individual suffering as Davis Floyd describes the medical colonization of childbirth. In a post-colonial society, Frank (2013) describes how the ill person has moved on from a sole responsibility of getting well to taking responsibility for what illness means in their life. In comparison, the fairly recent phenomenon of publicly sharing birth stories and dissatisfaction with maternity services across different media could reflect a similar post-colonial reclamation of experience and exploration of meaning described by Frank, but in relation to childbirth within the woman's life.

2.3.1 Memory and the story

We need to tell someone else a story that describes our experience because the process of creating a story also creates the memory structure that will contain the essence of the story for the rest of our lives. Frank (2013) describes talking as remembering, while Mead (Morris 2015) credits talking as the medium by which the social process of communication is imported into the individual and through which meaning emerges. Thus, remembering is considered an interpretive process that is embedded in the larger cultural world, formed from numerous interactions as the self is a socially constituted entity, from the experience of our body in space to the interpretation of social interaction, group belonging, media and cultural messaging (Misztal 2003). Thought is felt to be a reconstructive activity, as the attitudes and responses of others are imported and organised into one's self, impacting the shape of future interaction and behaviour (Morris 2015). This reconstruction and reinterpretation of experience can be considered to formulate our identity and be articulated within narrative (Guest 2016, Lawler 2014, Misztal 2003). Andrews et al (2013) describes this reinterpretation of events as ongoing throughout our lives as we continually rescript our past, connecting with ways of doing and being in light of subsequent events and our position in the present. People's stories report their reality as they need to tell it but there is no ending as any story stands to be revised in subsequent tellings. However, writing about stories is a second order act of narrative representation (Flyvberg 2001), particular to time and context of telling.

The initial narrative is itself an interpretation of the experience resulting from an interaction of feelings, sensations and events generated in the past and situated in the current dominant cultural modes of thinking (Misztal 2003). This interpretation of memories through reflective thought is situated within a larger selection process of which components will form the narrative (Morris 2015). These will be chosen because the narrator feels they have a point within the story, while gaining significance through their inclusion in the story (Lawler 2014).

As Frank (2013) and Widman & Farley (2001) describe, this selection begins to constitute the essence of the experience as the unnarrated elements fade, becoming the experience in the telling and its reception. The telling will be influenced by the position of the current self, the inclusion of wider cultural narratives and of the post experience state of the body (Misztal 2003). Andrews (2013) takes this a step further by describing how parts of our past may reveal themselves to have increased importance or even to become devoid of meaning depending on who we are now, but crucially it is also dependent on who we wish to become.

Since any listener of a story brings their own perspective of the world to the story, what is read is influenced by that framework of understanding. This position evolves over our life, bringing new perspectives to how we make sense of our own life and that of others. Therefore, human reality is only the reality of interpretation. As the nature of self is continually evolving (Morris 2015), so is the perspective with which we view the world and the stories within it. Consequently, we continually reinterpret the past from the changing perspective of today as different parts hold different significance. This is the same for the interpretation of story as our interpretation of today may be very different from last year. This leads to Bruner's dilemma of the hermeneutic circle where we try to justify the rightness of one reading of a story in relation to other readings of a story. I do not aim to justify the rightness of my reading of the stories of this project, but to clearly situate myself reflexively in relation to the stories to offer an interpretation set in a particular time.

2.3.2 Social Task of storytelling

The personal task of storytelling has been described as an external expression of the process of meaning making from an experience, but Frank (2013) describes the story told to also be social. This is because they are told to someone, and the shape of their telling is moulded by all the rhetorical expectations the storyteller has internalized about the topic. From these sources, storytellers have learned structures of narrative, conventional metaphors, imagery, and standards of what is and is not appropriate to tell. Whenever a new story is told, these expectations are reinforced, changed, and passed on to affect others.

The political component of social participation is explored by Drake (2002) in relation to birth storytelling which Widmann & Farley (2001) describe as symbolic representations of birth through words. In this way, birth stories can be used to preserve culture and explain human experience, document knowledge about community, the beauty of birth and stimulate change (Drake 2002). Sharing birth stories and receiving a reaction from the group or from the self with the internalisation of the attitude expressed in another's story, can encourage

reflection on the meanings ascribed to birth, deconstructing stereotypes by 'telling it how it is' (Letherby 2002). A story of birthing women's dependence can be continually created and reinforced by the communicative act of narration. In contrast, it may be challenged by another story of autonomy and agency through the use of the woman's body. For example, some women describe vocalisation during labour as a source of strength as opposed to a failure in breathing rhythm, defining what it means to be a woman in labour. This can open new ways of viewing the experience and an appreciation of the multiple ways of constructing the story (Widmann & Farley 2001). Antelius (2009) would take such an example to explore the performative aspects of narrative to the group, while other scholars would explore the agentic and political work of such a narrative (Andrews et al 2013, Bruner 1990, Cavarero 2000). Despite their differences, these theoretical perspectives agree that there is a social task to storytelling beyond Mead's requirement for an audience to the internal conversation (Morris 2015).

Frank (2013) offers an alternative view, discussing storytelling as a support medium for others experiencing similar needs. The dyadic body offers its own pain and receives reassurance that others recognise what afflicts it through the story. He considers a dyadic body with reference to illness as sitting in witness to others in pain, conferring this obligation to offer support. This perspective can be neatly translated to childbirth experience. The woman's experience of childbirth and the associated pain and labour is uniquely personal yet makes her aware of other women who have gone through birth and suffered their own personal pain, enacting bonds of solidarity across space and time (Butler 2012, Morris 2015). The proliferation of birth storytelling in the public domain could be interpreted as one way for the woman as a dyadic body to share her unique experience of pain and receive reassurance that others recognise that experience, performing their own rite of incorporation. This may be increasingly important in light of the negative consequences potentially attributable to incompleteness of the rite of passage.

However, birth stories often go beyond the reassurance of acknowledgement, carrying a message of encouragement or guidance for the reader in an effort to share experience and potentially assert a positive influence upon them (Carolan 2006). It can introduce different ways of framing an experience, offer an opportunity to gain an understanding of the woman's strengths, to discuss feelings of disappointment or inadequacy, connect with other women, and integrate major events into the framework of a mother's life (Callister 2004). Stewart (2003) equates the sharing of stories as a source of strength and survival among birthing women in remote areas of Australia. A sense of connection to other childbearing women and the universality of birth is proposed as a characteristic of birth storytelling as women

integrate the major event into the framework of their life (Callister 2004, Farley & Widman 2001). An overarching theme of validation of experience is used to encompass these findings (Carolan 2006), and links to Kramarae's muted group theory (2005) asserting that without a language or forum to articulate ideas, their validity falls into doubt. Stories are validating, confirming that you are not alone. They are instructive without being directive or prescriptive (Remer 2011).

A case study from Frank (2013 p141) speaks of a woman with a chronic illness who describes community with other sufferers of chronic pain as walking in different dimensions with access to different knowledge. Her knowledge is beyond speech and comes down to living as if it really mattered. I propose correlations with the experience of childbirth. Among women who have experienced childbirth, there is a sharing of experience regardless of the details of achieving birth conclusion. The different dimensions and knowledge refer to embodied knowledge of birth, of the corporeal precedence over the mind, the self/body harmony or disharmony, and its experience within the birthing system, creating an experience only the woman knows that transcends language but produces nodding acknowledgement in the meeting of others. This is described by Frank (2013) as the body seeing the reflection of its own suffering in the bodies of others. Kramarae (2005) would describe this as a shared meaning in an experience without appropriate linguistic tools to verbalise it, resulting in muteness of the group. The birth story's social task thus implicates those who read it, who stand as witness in a relationship of communicative bodies. The demand of such a task is for other bodies to commune with the teller in her pain as only through her pain has she learnt what matters, implying a social ethic (Mollica 2008). This explains Kitzinger's (1978) affirmation that giving birth is not a private act, but a social act, taking place in women's space. Within the current constitution of society, I suggest that women are using the communicative medium of the virtual world to create women's spaces online.

Chapter 3 Methodological approach

I decided to explore the post birth work of women's birth stories as the topic of my project following a shift in my perspective from professional to birthing woman in the birthing dyad. I had reoriented my view of birth from seeing it as a life changing event to appreciating the importance of the experiential learning from this event and the accompanying desire to share its story. This epistemological epiphany recalibrated my positivist orientation. I was previously asking *how* a birth story worked to integrate a birthing woman's changing identity into her sense of self. I had laid out the causal relationship between birth expectations and dissatisfaction with birth experience evident in numerous birth stories as resulting from the impact of birth vulnerability on the woman's sense of self. Following a period of intense theoretical engagement and supervisory guidance, I read a variety of scholars that supported the redirection in my enquiry to ask how a birth story incorporate the experience of vulnerability into the post birth identity but also *why* a birth story does work in the post birth life of a woman.

3.1 Research Question and Analysis Overview

The literature review has positioned my research question and objectives within the context of birthing in the UK, the findings from birth story analyses and the maternity literature so far. To situate my project, asking how do birth stories convey vulnerability in childbirth and incorporate the experience into the post birth identity and why the story does work, I have considered notable works across disciplines exploring concepts of identity and the body. To proceed, I have identified the symbolic interactionist epistemology of Mead (Morris 2015) as the philosophical underpinning for my project approach. Thus, within this section I will discuss the work of Mead (Morris 2015), and the intersection of his theory of the self with narrative. However, where Mead redefines the self as a product of socialization through role taking, I will explore the post structural enrichment of aspects of this interpretation. Accessing a variety of feminist and political works that include Judith Butler (1999, 2005, 2014, 2016) Foucault (2008) and Nicolas Rose (1999), I will explore the impact of discourse on the constitution of an individual's identity, enacted within narrative through performativity. Discourse can be defined as a way of thinking that is expressed through language (Ruiz 2009). The analysis of an interactionist perspective to post structuralist identity formation, will allow for discussion of the dominant and alternative discourses at play in the dialogic negotiation of the subject-position of the birthing mother. The philosophy of symbolic

interactionism as interpreted by Mead (Morris 2015) and later Denzin (1992), highlighted communication practices as the transfer vehicle for the systems of ideology or discourses that concern the work of Butler (1999, 2005). Focusing on the communication component of interaction to develop the theoretical underpinning of my project, I will also engage with the work of the feminist theorist Kramarae (2005), who built upon the muted group theory of anthropologist Edwin Ardener (1975). These epistemologies will be held together by embodiment theory, to explore the features of how minded bodies and social worlds fit together (Pitts-Taylor 2015). I will justify my choice of narrative analysis as my data analysis tool following a detailed presentation of data collection method and ethical considerations of the project.

3.2 An Interdisciplinary Approach to Storytelling

While the epistemology of my project is firmly rooted within the philosophy of symbolic interactionism, I acknowledge the influence of post structuralist scholarship in the provision of resources to shape that interaction. According to Denzin's (1992) review of the field, symbolic interactionism and specifically the work of Mead from the 1920's (Morris 2015), adapted by Blumer (1969), Goffman (1959) and Polkinghorne (1988), theorises the individual self to be constituted in a continual process of social interaction and self-reflection. It proceeds on the assumption that humans create the world of experience they live in, by acting on things in terms of the meanings they hold for them. Thus, experience is not preconceived, upon which interpretations of the world then rest. Rather, it is seen as a dynamic concept, unfolding through time, and characterised by the continuous interaction between the body, the self and the personal, social and material environment. Mead (Morris 2015) emphasised the relational aspect of this process, postulating the self to arise through social experience and activity. He felt the self, as a result of its reflexivity, to develop within an individual as a result of their relationship to that process and to other individuals within that process. He places the individual as the reconstructive centre of society, reproducing society through the structures of cultural meanings. These cultural meanings are explained by a variety of scholars, including Denzin (1992) and Foucault (2008), as the systems of ideology and power that are shared and reinforced through communication practices. This social discourse provides the context against which the content of experience is lived. An example of such a discourse used to govern social groups could be the current emphasis on autonomy as the goal of the self within UK society. This goal is to be achieved through adherence to a set of normative criteria or behaviours set out by 'experts' and is supported by social structures that can be observed in institutional tactics to control the behaviour of

the collective (Foucault 2008, Sokhi-Bully 2014). They encourage self-regulation in a continuous 'project of the self' (Foucault 2008, Lawler 2014, Rose 1999). Foucault (2008) stated this focus on autonomy and individualism or neoliberalism, to be an example of the indirect style of social control, the 'conduct of conduct' typical of governing approaches to produce a governable subject.

The alignment between symbolic interactionism, post structuralism and feminism is a natural one as all three explore the impact of power and its reinforcement within the structures of society (Tamboukou 2013). Feminist research is based on women's lived experience in male dominated systems of society, on gender as a socially constructed and historically specific construct and on a political commitment to the emancipation of women (Butler 1999, Lentin 1999). Within this summarising statement of an eclectic branch of emancipatory theory, sits the particular muted group theory of Ardener (1975). Taking a Foucauldian approach to the analysis of discourse, he focused on how marginalised groups are excluded and silenced through the linguist power of access to language. It describes how those creating the language use it most effectively compared with other groups who learn to use it as best they can. This inequity can lead to the non-dominant group being unable to fully express themselves. As a result, they are 'muted' or silenced as the language available to them to articulate their experiences is not adequate. The original presentation of this theory was in relation to male dominance in society with male based understandings representing the dominant view, and women thus experiencing muteness as a result. This example of discursive power serves to perpetuate patriarchal values as dominant norms, mystifying the presence of discrimination (Verdonk & Abma 2013). Kramarae (2005) expanded this original interpretation to encompass all non-dominant groups within society. She went on to highlight the intersection of identities and developed the muting concept to include the influence of social control, ritual and ridicule through the trivialising of the speech pattern and lexicon used by the non-dominant groups. Within the context of my project, a lack of linguistic choice to describe the bodily experience of birth outside of the self, alongside a disregard of non-rational ways of knowing, could distort a woman's birth account. This distortion can impact the interpretation of the experience by the woman and its legitimacy in society. This restriction on or failure to articulate one's ideas, can lead to doubt about the validity of the experience and the consequent authority of the associated feelings, representing another way in which we are made subjects (Foucault 2008)

Women's experiences must be discussed within the context of the body as it is the female body that is embedded in an oppressive matrix of power and subjecting ideology (Foucault 1978, Krook 2007). I have touched upon this in the literature review, exploring the sociohistorical concepts of inadequacy, exposure and vulnerability in relation to the birthing

body. Moving deeper into the theoretical debate of embodiment focuses on the way corporeal characteristics surface in our experience of ourselves and others. This formation of embodied subjectivity as constitutive of the self involves traversing a theoretical discussion about the entanglement of 'natural' and 'social' elements in experience. Within Judith Butler's (2005) post structuralist framework, experience is treated with suspicion because of the implication that the body and the world are offered in an unmediated way. She argues that what we count as the material body is arguably the product of particular modes of conceptualising. Bordo (1993) attributes this to dominant discourses in society that prescribe norms in relation to which subjects regulate their own bodies and the bodies of others. Elias (1994) relates this to an increasing emphasis on self-control, social order and hygiene within the moral training of the home from the pre-modern time of the Renaissance that traps us in a continuous process of self-scrutiny, watching for signs of unhealthy attitudes or desires. Foucault describes this constant working to be a certain type of self as a 'project of the self' (Foucault 2008). This project is fed by authoritative knowledge of 'experts' that work through our desires by generating them, focusing on the illusion of autonomy as the goal of the self (Rose 1999). This project of the self is achieved through self-monitoring, accessing 'expertise' to promote self-actualization, the exercise of choice and desire for self-development. This expert knowledge connects the aspirations of the authorities with the projects that are individual lives. They serve to forge new alignments between the techniques of power and the values of society. Such techniques organize people in both space and time to achieve certain outcomes. Within this theory of governmentality, dependency, or lack of autonomy is thus seen as personal pathology, with the therapeutic culture on hand to resolve any problems that in reality are the internalised reflection of social inequality and disease.

Butler (2005) develops the influence of discourse, arguing subjection of our bodies to these normalizing practices becomes the process where sexed and gendered subjects come in to existence. This works on the premise of the immediacy of our perceptual response to the material features of these identity categories becoming naturalised. The fact that they are the product of learned modes of perception is not evident to us because such perceptual practices have become habitual and are resistant to change (Lennon 2014). This is how Foucault's theory of governmentality operates, through the indirect shaping of 'free' social practices (2008). Consequently, the sense of our own body reflects the way it is perceived by others. The work of Young (2005) captures everyday experiences of women's embodiment to make evident the way social norms govern the female 'bodily comportment'. This restriction yields an inhibited intentionality or interruption in the pre-reflexive engagement with the environment. Young (2005) suggests this inhibition to be derived from

women's experiencing their bodies as looked at and acted upon, which is a situation of women in contemporary society. What is stressed in the feminist literature is the range of philosophical theories which are required to make sense of the embodied self. While I have rooted my project in a symbolic interactionist epistemology, I acknowledge the influence of post structuralism in shaping the interaction, and I return to the recognition of the category of woman as fragmented and situated. Furthermore, taking a reflexive approach and writing myself into the text is an essential component in revealing the influence of my interaction between my assumptions, positionality and the stories of the participants of my project (Nencel 2014).

Mead (Morris 2015) acknowledged a variety of different selves within the individual that answer to different social reactions. Consequently, he proposed 'selves' to be constituted in terms of the social processes within which the individual engages. As a result, the self is essentially a social structure arising out of social experience. The experience of being and knowing, encompassing stimuli of the mind, emotions and body reflects the dynamism of experience according to Mead (Morris 2015). The 'affective turn' of embodiment theory considers affect to be the relational mediator between the body and everyday life sensations and feelings to shape cultural practices and enable identity work (Spinney 2015). The reliance on affect and emotion is a quick and efficient way to navigate our complex and unpredictable world (Slovic et al 2005). Most women's narratives of birth, including those accessed for this project, are laden with emotion and experientially derived knowledge (Akrich & Pasveer 2004). When I wrote my 2 birth stories, I began quite factual and constrained but then the emotion contained within the memory took on a life of its own and carried the direction of the story, both expressing the emotion of certain components of the event and viscerally prompting the orientation of the story line. Misztal (2003) describes strong emotion as blurring the mind – body distinction, resulting in vivid and somatic memory stories. Such knowledge is used by people to make sense of the world. This 'sense-making' requires knowing with the body, as it is the lived and felt experience of being in a body, interacting with the world and other actors within it through all the bodily senses that informs our understanding and connects language to the world of experience (Schilling 2016, Todres 2007). Thus, experience is situated in embodied and spatialised settings. As a result, the material and discursive are in a constant process of producing embodied subjectivities in dynamic relation with others and with the world (Del Busso & Reavey 2011). The body does sometimes fade to the background under the power of language (Walsh 2010), but its articulation is informed by a holistic process of preconceptual learning by the body-mind system (Ellingson 2017).

The storying of our identity is how we make sense of ourselves and create meaning in our interaction with the world around us (Guest 2016). From a theoretical perspective, Mead's work, collated by Morris (2015) unpacks this assumption as he describes the process of becoming as originating from what we say resulting in a certain response from another. Working on the memory of this response in turn changes our action or story from what we started to do or say. Mead describes this process within thought as an inner conversation implying an audience, that eventually requires an audience for actualisation of the self. Out of this narrative truth, a sense of coherence can be restored to the flux of intersecting identities and experiences. Within the childbirth context, Akrich & Pasveer (2004) interpret the 'I' in the narrative as an embodied self, while Mead describes the 'I' as the actor, aware of and reacting to the social 'me' or self that arises in a social process of taking the attitudes of others. This illustrates Akrich & Pasveer's (2004) assertion that the self is not fully distinguishable from the story, nor reducible to the contents of the story, yet *who* the self is, is revealed in the story. Within this perspective, applying a different level of attention to describe stories told through the body as opposed to observing what stories say about the body is an intuitive recommendation, as the body is created in the stories they tell (Frank 2013).

The foundation of Mead's philosophy is that this process of meaning making is profoundly social. He describes a triadic relation upon which the existence of meaning is based. This relation involves the act initiated from the interaction of the individual to the adjusted reaction of another. Such a response gives the gesture meaning within the matrix of interactions that constitute an experience. Mead develops the influence of this category membership upon the social attitudes to which the individual is exposed and are included as elements in the structure or constitution of their self. Developing this approach, Butler (2005) argues these attitudes to be a response to learned modes of perception originating from prescribed social norms or discourses. Within such a post structuralist view, it is the dominant discourses within society that are credited with defining and controlling this 'category membership' referred to by Mead (Bordo 1993, Foucault 2008).

In the words of Mead, this response to interaction is how the pattern of social or group behaviour enters into the individual experience, and he classifies the process as the framework of the self. Within this framework there are many different selves answering to all sorts of different social reactions. Current terminology would label this as the intersection of identities, moving on from the idea of isolated selves to expose their interdependent impact upon each other. For example, experience of the mother identity category will differ for women depending on its intersection with categories such as ethnicity, age and class. Verdonk & Abma (2013) illustrate how the discrimination of black women in the legal system

is greater than the sum of racism and sexism. However, Mead focuses on the influence of the social process itself for the appearance of the self rather than the origin of the content of that interaction. Within this project, I take a Foucauldian view by proposing the social interaction responses and content to be formed and guided by the numerous discourses within society.

Fundamental to the feminist debate is membership of the oppressed group as a pre-requisite for any comment or research. I identify with membership of an oppressed group in my role as a midwife 'selling' a system that did not support my view of birth, and latterly as a birthing woman negotiating my space within this suppressive system. Within this subject position my literature review and methodological underpinning support each other. I have shown how the rise of medical knowledge as the dominant knowledge system in birth is reinforced by the surrounding social structures, and is responsible for the subliminal messaging during birth seen in women's demand for a service that is suppressing openness to alternative knowledge around birth.

3.3 The Study Design

A selection of 20 birth stories, posted on a popular 'mums' internet forum was accessed by the researcher and subjected to a multi component narrative analysis technique as described and advocated by Reissman (2008).

3.3.1. Internet Based Media

With the proliferation of the internet over the last 20 years, the way people communicate with each other, access and share information resources has changed. With a recorded 89% of women using the internet within the last 3 months in the UK (Prescott 2018), it is no surprise that the role of mediated communication continues to increase with a significant proportion of personal communication being replaced by technological communication (Remer 2011). Computer mediated communication (CMC) has been hailed as increasing gender equality and levelling power relations between groups by rendering difference invisible. CMC has been found to increase among females where the audience is known on the communication site, with an increasing trend towards the use of real names and posting of pictures, suggesting an accrual of social capital by the activity (Herring & Stoerger 2014, Vermeren 2015).

3.3.2. An Alternative Communication System – The story

As I have already introduced, Kramarae (2005) describes strategies that are used by muted groups to overcome the muting process. These are described as naming the silencing factors, celebrating the group discourse, adding new words to the language system and communicating with each other using media platforms that give voice to the group. These platforms may not be the same as those used by the dominant group, which within the context of this project is the institution of obstetrics. This use of accessible platforms to give voice to the group could explain the explosion of birth stories across the internet in blogs, forums and chat rooms as women seek ways to share their experience. This communication media of story is in contrast to the context free, scientific presentation of data by the dominant maternity care communicators in conference presentations, peer reviewed scientific trials and observational case studies.

Bruner (1991) described the tellability of a story as resting on a breach of conventional expectation. Since a breach presupposes a norm, narrative therefore is concerned with cultural legitimacy. How the notion of breach is conceived reveals different cultural emphases, as they are shaped by the social, cultural and institutional narratives within which the experience is expressed and enacted. Society thus passes on its values through the reflective lens of the story. Stories are assembled and told to someone somewhere for a particular reason with a variety of consequences. These considerations impact the content and emphasis of what is told as storytelling has a purpose beyond straightforward description (Gubrium & Holstein 2009, Savage 2001). Metaphors are frequently used in storytelling and show how narrative is based in bodily experience to create spatial presence for the self or to pass on practices of being and doing the body (Misztal 2003). A characteristic of stories is that they accrue, creating a history or culture. It is a sense of belonging to the underlying cultural expectation that allows us to form our own narratives of deviation while maintaining complicity with the underlying cultural understandings that prevents alienation. For a culture to operate effectively, social beliefs and procedures (ethnosociology) must be widely shared, with the story as a way to achieve this.

For Bruner (1991) the central concern is not about the textual construction of the story but rather how it operates in the construction of reality in the teller's mind. Fundamentally is the realisation that all narratives are co-constructions. The audience exert a crucial influence on what is said, what is not said and how things are expressed. As such, storytelling happens relationally in a context. A process of ordering is imposed upon the story by the narrator to facilitate the audience's understanding of another's world (Salmon & Reissman 2013). Thus,

while the occasion and context own the story, the intended audience also play a role. A storyteller is not waiting for their stories to be accessed; they are co-constructed with the listener. As there is no narrative identity without an audience, it can be said that forms of identity are thus embedded within a collective identity, for example, the identity of birthing mother in the stories of this project. Despite different experiences of birth, each storyteller experienced the transition through birth to take up an identity of mother. This has been described as kinship work in action as relationships are constituted that include some and exclude others (Lawler 2014). This is because the response of the listener, or perceived response in the case of 'virtual' listeners, is implicated in the art of the storytelling thus identities are situated and accomplished with the audience in mind (Bruner 1991, Georgakopoulou 2006).

Working with the disembodied medium of text will always require reflection on the embodied response of me, the researcher, as reader of the story. However, reading a story can account for a sensation of immediacy of presence in the story (Adams & von-Manen 2006), and is in itself a bodily experience as active interpretation of the story makes use of previous bodily experiences of the reader (Hyden 2013). Returning to the stories of this project following my own childbirth experiences will enable the full exploitation of this aspect of the research.

3.4 The Data Collection Process

3.4.1 Research context

A series of 20 consecutive birth stories were selected from the public noticeboard of a popular 'mums' website. The website claims to have 1.9 million members, with 8 million or more visitors to the site each month. The site is packed with information on an array of pregnancy, birth, parenting, child development, play ideas, recipes, money saving tips from professionals and other mums. There are trending threads of discussion and a whole menu of chat topics in a designated section of the website. When I first accessed the site to sample the birth stories they were in a 'birth story' section where women were invited to share their birth story for the chance to win a prize. Interestingly no prizes were awarded in the two years (2012-2014) I monitored the site, and no birth stories were showcased or put forward as winners. This noticeboard was accessible without site membership but only members were allowed to post stories or chat style comments. When I returned to my project after my 2-year maternity break, the website had undergone a transformation. The graphics looked very professional, the pages were full of pop up adverts for products and the birth stories had been changed. They were no longer easy to find, and when I did locate

them they comprised of examples of positive birth experiences in different settings accompanied by published encouraging comments from other mothers alongside reports on celebrity births. There was no opportunity for readers to leave comments, ask questions or develop a thread in response to the posted story. It no longer felt like an interactive chat room. The use of shared language abbreviations and emoticons for emotional expression that had peppered the stories of my project, was missing from the new, polished style of account.

3.4.2 Anticipated problems

When I first accessed the website to select stories for my project, they were posted in response to an invitation to submit your birth story with the best one winning a prize. The prize was not described, a closing date to the competition was not advertised, and previous winners' stories were not showcased. This invitation may have prompted the sensationalising of an experience to catch the judges' attention or exclude women who would not describe their experience as dramatic or carrying a particularly entertaining thread. However, the lack of follow up to the original invitation made the competition aspect fall in to the background, with a feeling that posters were sharing their stories without looking for a prize. For example, some stories carried response comments with sharing of experience in return from fellow posters, turning into a chat session rather than a story competition. However, with the original competition invitation in mind, I carefully reviewed each story and while some were dramatic, there was enough variation in my sample to capture uncomplicated and non-dramatic reports.

Chadwick (2014) describes two culturally normative birth story formats of the 'western' world in her paper on counter-narratives. The first is generally composed of a complication, near disaster but with a happy ending equating to a happy baby and intact mother. Usually the 'disaster' has only just been averted, and most frequently this was by medical intervention rather than the hero being an action of the mother. The second normative story can be badged as a 'horror story' emphasising the gruesome nature of birth accompanied by descriptors of pain and drama. She has found these to be on the rise in the western context. However, within the hundreds of posted stories I read on the 'mums' site, there was a variety, from drama to trauma to humour and factual exchanges of information.

I checked the stories I had selected to ensure there was not thematic posting in response to a leading narrative. I found within my data set a range of style, from long detailed testimonials to short factual pieces apparently lacking in text reflection or evaluation with a couple of 'dramatic' stories of both positive and negative outcome. There was one political

commentary on birthing culture within the context of the narrators' birth experience. This story format was very different from the rest and didn't fit the dominant style. However, rigorous research requires inclusion and even search for 'outliers' to illuminate the context and data. This difficult story has since become a major contributor to the data analysis as I read more about ethics in working with others' stories and in the fundamental principles of feminist research. As a result, I felt the variety evident within my data set suggested it was not polarized towards 'dramatic' storytelling.

3.4.3 Access, Ethics and Consent

If the identity of the participant is not recorded and the communication can be easily accessed by the researcher, then according to Kozinets (2010), this is not regarded as human subject research requiring specific ethical consent. Such non-intrusive web-based research that doesn't interrupt the naturally occurring state of the site or cyber community is compared with naturalistic observation in a public space (Kitchin 2008, Rodham & Gavin 2006). Such data can then be used in the same way as text. However, the internet is neither a public or private space, and neither is it just text. It is a unique medium with numerous styles of interaction intended for numerous specific and general audiences.

While the data used for my project falls in to this category, I am very aware that use of the internet is a relatively new field of research with online technology and its governance continually evolving. With this in mind, I have followed the recommendations of Kozinets (2010) to practice maximum concealment of the participants, doing everything possible to disguise their identity. To achieve the highest level of protection for the identity of the storytellers, I refer to the online site used to access the birth stories as a popular 'mums' website. I contacted the management team of this site asking how to gain permission for the use of birth stories posted on their site. They replied that since they were posted publicly, the women were aware of the public location of their story. They were also reminded by a message in the page header that the page could be accessed without site membership. As a result, they gave their permission for me to use the stories as long as I respected the confidentiality of the storyteller and submitted a summary of the project findings to the team at the end of the project.

The use of data without consent only remains ethical if confidentiality is strictly maintained, as an important feature of online posting is the perception of anonymity that it offers. This anonymity has been shown to allow users to express themselves in ways that may be constrained in real world interactions (Waskul & Douglass 1997). As the topic of the birth stories selected for this project is potentially sensitive, intimate and identifiable through the

specific configuration of events, the respect for confidentiality is essential. Furthermore, while many of the storytellers posted under only a membership number, some included an identifiable name such as ‘Mary’, or a username such as ‘PixieBubble’. To maximise confidentiality, I have given pseudonyms to the storytellers and withheld specific location details inferred from the postings. I had originally included an overview of storyteller locations to illustrate a potential spread of experience from across the country. However, since some mothers were posting about births that had happened up to 10 years previously, I felt these locations would not be very relevant. Due to redesign of the website since starting this project, the original stories have now been removed and cannot be traced by typing quotes into a search engine.

The researcher has an ethical obligation to explore their impact on the data, present the participants’ voice in the research report and to disseminate the results to effect change in the wider social world. Reflexivity is a key component of feminist research practice and is an awareness of how the researcher’s values, attitudes and perceptions influence the research process from asking the question throughout data collection to interpretation and reporting (Norum, 2000; Primeau, 2003). The data set of this project was created without my influence on its content, negating the need for exploration of the personal dynamic between myself and the storyteller and how it may have influenced the content or emphasis in the story. However, despite using the words, descriptions and experiences of the participants, I am aware that I am the author of the representations within this project. Each representation of their story reflects my interpretation of the experiences shared by the women telling these stories. I am the one who read the stories and decided to pursue the representations that I have included.

The stories of this project are self-narrated stories which Gready (2013) describes as offering ‘transitory forms of power’. It allows the narrator to relive, control, transform, (re) imagine events, to reclaim and construct chosen identities, social interactions and communities. He asks the question, ‘Is the right to narration not just to tell one’s story but to control one’s representation?’. However, there is a risk of components of the narrative overshadowing the narrator’s intent in telling the story and altering their representation emphasises the profound political and ethical dimensions of working with others’ stories. Gready (2013) classifies this act as selective listening and consequently rendering the marginalized speechless. Taking a multi layered analytical approach of structural, thematic and dialogic narrative analysis through my clearly defined question, I aim to minimise a potentially polarised view.

Within this context, I needed to review my position while respectfully exploring the stories, asking myself what can be done with the resulting awareness and dissemination of the stories beyond the space they were intended to reside. When I sampled the stories from the online site, it was from my position as a midwife, and a doctoral student. I very much felt an 'outsider' to the mother's club I was witnessing, yet felt I had the tools to offer hidden insights from the stories. After returning to the data following my 2-year maternity break, I listened to the stories from a more embodied, personal perspective. I had shared an experience with these narrators, twice, and felt a relational kinship with them. Consequently, I had returned to the data as an insider, as part of the mother group. My ethical responsibility in relationship with the data is to use any findings from this project to facilitate understanding among birth workers that a birth experience is multi-layered and complex.

3.4.4 Participants

The inclusion criterion for this project was that the birth story had to describe a childbirth experience that included labour and birth. The 20 stories forming the body of data for this project, were a selection of many hundreds that had been posted in the publicly accessible section of the 'mums' website. In an attempt to take an unbiased sample of stories, I started from a story posted on the 1st of October 2012, taking the next 20. I did skip a couple as they did not share any aspect of the labour and only reported the birth or were a comment on postnatal care. In this way I am defining what constitutes a birth story for the purpose of my project.

Although demographic details of site users were not available, self-description within the stories and recording of membership region next to the membership number at the top of the birth story, revealed a significant geographical distribution, age range (from teenagers to over 40's) and relationship status of the posting members. The predominant ethnicity appears to be white British though there were self-identifying European and British Asian women sharing their birth stories.

3.4.5 Methodological modifications

Following my maternity break from this project, my relationship to the data became more subjective and the interpretation became more informed by my personal experience. My learning and growth as a woman, a mother and as a researcher has influenced the direction and consequent findings of this project. Therefore, I felt a need to reflect on my journey and include my processual becoming into the evolutionary description of this project. The

methodological guidance of critical autobiography offered a framework to achieve this in a reflexive way that did not eclipse the stories of my project participants (Walker 2017). Incorporating this approach has allowed me to deconstruct how the different paradigms of knowledge within me have been developed and framed through my lived experience of midwifery and childbirth. As a researcher I am an instrument within my research thus the analysis of data and construction of meanings is based on my personal understandings and connections to the narrative. Including my story within this project socially locates me in relation to the data and furnishes the reader with insight into how my experiences have contributed to the development of my identity (Polkinghorne 1988).

This change in my relation with the data made me more aware of the constraints of the structural analysis framework I had originally applied to the stories, and prompted the inclusion of thematic and dialogic analyses as used in the narrative approach of Reissman (2008). I felt choosing these tools would restore agency to the participants by respecting subjectivity and preserving their account. This is because within this method, stories are presented intact as opposed to being broken and presented as generalisable codes (Reissman 2008). Agentic storytelling is the subject of the experience focused narrative analysis tradition (Squire 2013). Taking a dialogic approach to analysis also fits well with a feminist perspective on the research question as it can support the emergence of counter narratives in the narrative contradictions and humour, that don't categorise easily into the structural components of Labov & Waletzky's structural analysis framework. These components of narrative can reveal 'cracks in the system' or moments of resistance. Within an online story format as opposed to a face to face interaction, this evidence could be hidden in the use of emoticons, exclamation marks and bold or italic emphasis in the text.

3.5 Approaches to Data Analysis

3.5.1 Overview of Narrative Analysis

Narrative analysis is embedded within a tradition of inquiry concerned with understanding how people make sense of their lives and how analysts can access that understanding (Lawler 2014). This project has so far discussed how stories do work for both teller and listener. It has shown how immensely powerful stories can be on both a personal and social level. A critical point that I have emphasised is that stories are co-constructed with a myriad of actors that are present, past and imagined. Furthermore, they act as a site that combines numerous influential strands of discourse. Within this complex landscape there are some shared characteristics that can aid their interpretation and analysis. Principally, stories of the western tradition (illustrated by the stories used as data for this project) have a shared

structure within time and space that present a consequential linking of ideas or events, classically with a beginning, middle, end and ordering of events into a plot (Reissman 2008). The representation of the experience reconstitutes it, in addition to expressing it, because it is through consideration of the story as a whole, that the values and meaning making of the teller become clear (Bruner 1991, Ricoeur 1980). It is the reconstitution element that brings in the influence of memory and dialogic co-construction through performance and interactive interpretation. The analysis of narrative from this perspective of reconstituted experience, signifies the 'second wave' of narrative analysis from in-text to in-context (Georgakopoulou 2006), and looks at how narrative is performed and accomplishes particular tasks.

The practice of narrative analysis advocated by Reissman (2008), takes this in to account by looking at the work achieved by narratives on three different levels: through the structural composition, the dialogic function, and the interpretation of themes in relation to the wider theoretical literature. I decided to use these three analytical tools with my data set as I felt it enabled me to access different subjectivities within the stories. While the use of three analytical tools may feel cumbersome, I feel it provides a holistic interpretation of my data set. The use of three tools also adds robustness and depth to the analysis, overcoming the potential limitations of a small amount of data. I will discuss each tool in the context of its application to my project.

3.5.2 Structural Analysis

Firstly, I bracketed my knowledge of the whole story and concentrated on the 'telling' element of the story while applying structural analysis. Structural analysis explores how the narrative is organised to achieve its aim, namely to convince the listener that the sequence of events related, and their impact on the narrator actually happened. Specifically emphasised are the uses of language and form to achieve particular effects. The 'western' storytelling tradition reflecting the positivist domination of society is taught from a very young age as a structured, chronological collection of events with a purpose. This model fits Labov and Waletzky's structural analysis format (1967), and is the structure found in the birth stories of interest to this project. Despite the positivist orientation of this approach, the pragmatic, structured process supported my introduction to reading stories from an analytical perspective. They described six elements contained within a narrative, in a variety of orders. These are: (1) an abstract – detailing a summary or the 'point' of the story; (2) orientation – to time, place and characters; (3) complicating action – the plot, usually containing a crisis point; (4) evaluation – where meaning and emotion is provided by the narrator; (5) resolution – the outcome of the plot and (6) a coda – bringing the story back to the present and to an

end. Not all stories contain all elements, and they can occur in varying sequences. Through ground breaking work, Labov & Waletzky (1967) illustrated how the arrangement of these structural elements and exposure of their function in the narrative can greatly enhance interpretation of the relationship between meaning and action in a story, even assisting the identification of thematic issues.

However, while the framework of Labov & Waletzky (1967) offers a detailed and rigorous starting point to identification and analysis of narrative, their methodology did not feel fully suitable when I engaged with my data set. Principally, I encountered frustration at the lack of fit of the structural classifications to numerous sections of the birth stories used in this project. Difficulty in structural classification, or when the primary function of the clause is unclear, has been identified by others as a limitation of this model (Patterson 2013). This limitation left many sections of the story unclassified and a risk of losing vital context that would inform the mini-narratives I had identified. Reissman (2008) overcomes this issue with a reconceptualization of narrative from Labov's narrow definition of a sequence of two temporarily ordered clauses. She describes an entire interview response as an 'overarching narrative' if there is sequential, thematic and structural coherence and that even the notion of imagined experience is crucial to the process of narration of past events. In contradiction, Frank's (2013) chaos narrative would sit outside this description as it provides deep insight into experience precisely through its lack of sequential, structural coherence.

Unbeknown to me at the beginning of my analysis, Labov and Waletzky have been credited with working on event narratives while clearly, I was dealing with experience narratives. The reading of birth as an experience as opposed to an event was the fundamental shift in orientation of my project after moving from the perspective of professional to that of birthing woman in the childbirth dyad. This is now the fundamental tenet of my project, that birth is an experience and not an event. This misclassification could lie at the heart of women's dissatisfaction with childbirth care. The lack of fit I felt with Labov and Waletzky's (1967) approach emphasises the importance of this distinction and sent me back to the literature to search for alternative analysis tools. During this literary reassessment, I learned that their approach had been critiqued as decontextualized from interaction and context (Patterson 2013). Consequently, a different approach was clearly required for my experience narrative data to release the evidence of how interacting individuals connect their lived experience to the cultural representation of those experiences contained within their story. It was at this point that I discovered the more epistemologically congruent work of Reissman (2008) and the inclusion of both thematic and dialogic analysis in my methodology. This methodological evolution reflects the development of my personal theoretical understanding and pragmatic abilities through the course of my project. However, Labov and Waletzky's (1967) structural

analysis approach still holds relevance and value as an opening engagement with my data set and remains a part of my project with a recognition of its constraints.

3.5.3 Thematic Analysis

Following the structural analysis, I returned to the text as a whole and conducted a separate thematic analysis to focus on the context revealed in the stories. Thematic analysis is characterised by searching repeatedly across the data to find patterns of meaning, guided by the theoretical framework of the researcher (Attride-Stirling 2001). Within this project, I initially took an inductive approach to the corpus of 20 birth stories. Following immersion in these stories I proceeded with detailed coding without a pre-existing coding framework, trying to build a picture of what women share in online birth stories. This led to engagement with concepts and theories in the wider literature and refinement of the research question. The data was then revisited in light of the theoretical suggestions, recoding and merging coded elements of interest to embodiment, vulnerability and identity (Braun & Clarke 2006). Analysis of patterns allows underlying meanings and conceptualisations to be unpicked and thus credited with shaping the data. This results in wider theorising about the socio-cultural conditions and structural conditions enabling the construction of the data (Braun & Clarke 2006). This process resulted in further interpretation and refinement of the data to present four themes. In line with Reissman's (2008) approach, narratives were then selected to illustrate the developing theoretical arguments emerging out of the analysis and the connection between personal stories and larger social concepts.

3.5.4 Dialogic Analysis

The structural and thematic analyses broke down the text of the stories into manageable sections, however this can make the co-construction of meaning with the audience and context invisible. Consequently, I returned to each story as a whole to analyse the influencing discourses within which it appeared embedded. The principle assumptions of dialogism, according to Bakhtin (1981) and Mead (Morris 2015), emphasise the constitutive power of social construction, the importance of discourse, identities and relationships, and the historicity of language or multivocality of the text in the creation of meaning. I have laid out my theoretical position that orients my interpretation and understanding of this context in the generation of meaning in the literature review and methodological chapters of this project.

Gillespie & Cornish (2014) propose 'sensitising questions' to facilitate this process of interpretation, guiding the researcher in their role as instrument. These questions

deconstruct dialogic theory into prompts for interpretation, highlighting particular components of the data that may open productive lines of inquiry. The first question asks, what is the context? This refers to the whole situation of the story and includes the setting and the participants. Gillespie et al (2012) emphasise how people's mobility between contexts can cause 'collision', where the concerns and audiences of one context are psychologically present in another. The co-construction of the birth story with the perceived audience of the forum accessed for this project takes place through a macro social context of childbirth and the expectation of the role of the woman and significant others within it. The second sensitising question is, what is the speaker doing? Statements are considered in linguistics to be actions and that people do things with words (Wittgenstein 1953). Consequently, what people say can shape the future by suppressing alternative futures. As narratives are constructed in retrospect, early details (such as the abstract clause of structural analysis) can be seen to direct the journey of the narrative. The third question asks who is being addressed? All speech is addressed to an audience, who Bakhtin (1986) describes as shaping what is said. Gillespie (2006) feels this shaping is based on assumptions held by the storyteller of the audience's perspective. These assumptions will inform the composition and negotiation of the storyteller's identity performance which is tested out through the telling of the story (Goffman 1959). This performativity impacts on the content and presentation of the story to the extent that the environment and occasion own the story as much as the narrator (Gubrium & Holstein 2009), suggesting identities are situated and accomplished with an audience in mind.

The context, purpose and audience of the story influence what is said by the storyteller. However, this is contained within the impact of pre-existing discourse that is accessed through the question, who is doing the speaking? (Gillespie & Cornish 2014). This perspective considers words to be connected with their own history and the contexts within which they have lived (Bakhtin 1986). Pre-existing discourse is accessed and amalgamated to construct and justify a sense of 'self' and if appropriate to the context, of an 'other' and is revealed in the contextually dependent references employed in the relay of the story. As such, these stories share as much about a society and points of culture as they do about a person (Reissman 2008). They can reflect institutional influences on the personal story (Gubrium & Holstein 2009). Thus, every text carries hidden voices of politics, history and culture, and the author does not hold unique authority over its meaning. This multivocality of the story or saturation of words with ideology and previous meanings creates opportunities for multi-layered analysis (Bakhtin 1981). The use of quotations and ventriloquations destabilise who is doing the talking and may reflect common culture ideas or narratives contained within these discourses. Such a normative pattern of expectation can create a

micro-culture that furnishes the storyteller with both expectations and accepted responses (Gillespie & Cornish 2014), reproducing the identity of the storyteller and their audience within the light of those assumptions. This positionality is explored through the fifth question of what future is constituted? Something new is created through speech though it is created for a purpose. Bakhtin (1986) describes that while the words do something in their new context, they usually offer no more than minute variations on the prevailing social order which is revealed in the exchange. However, within this context is an additional constraint of available resources for the storyteller to make sense of their narrative identity within the master narratives of culture, their normative values and communication systems (Butler 1999, Kramarae 2005, Lawler 2014). Chadwick (2014) argues the dialogic approach to analysis to offer an opportunity to hear this multi-vocality within stories.

Chapter 4 Analysis

Twenty birth stories were selected from a popular 'mums' website between October and December 2012. These stories ranged from a few lines of factual statement of events to detailed descriptions of the experience extending for a few pages. From these 20, 18 reported on hospital birth experiences with 11 as normal births and 7 as receiving assistance for birth, 4 told stories of homebirth. Two stories shared births of previous children in the narrative. The delay between birth and telling the story ranged from 4 months to 8 years. Demographic details of site users were not available. Self-description within the stories and recording of membership region next to the membership number at the top of the birth story, revealed a significant geographical distribution of story posters, age range (from teenagers to over 40's) and relationship status of the posting members. All storytellers have been given pseudonyms to protect their anonymity.

The stories of this project were first subjected to structural analysis followed by thematic analysis. I returned to the structural analysis after thematic review and refined my findings. The results from both tools were then revisited following another reading of the data set, to set a firm foundation for the dialogic analysis. These are presented last as the report of the findings moves from the specifics of structural analysis, through shared categories of (1) White Noise (2) Doing the Body (3) Bargaining Authenticity and (4) Witness to Transition, to the contextual dimension of the dialogic.

4.1 Structural analysis

I used the structural analysis framework described by Labov and Waletzky (1967) as the first approach in the analysis of my data set. Their framework is designed on the assumption that a story presents a structured, chronological collection of events revolving around a purpose. The relationship between meaning and action within the story through the function of different structural components, forms the basis of their theory. There are 6 component parts of their structure. These may not present in sequential order and may not all be present in every story. The six components of their framework are named as; abstract, orientation, complicating action, evaluation, resolution and coda. The abstract functions to describe the sequence of events in the narrative while the orientation clauses orient the audience to the context of the story and often include details such as time, place, people and behaviours. The complicating action within the narrative classifies the main body of the story, with evaluation clauses providing information on the consequences of the narrative event for human needs or desires. The resolution of the narrative is the set of actions that follow the

most reportable event, with the coda returning the listener to the present from the world of the story to the world of the storytelling event.

The birth stories of this project matched the story format of Labov and Waletzky (1967) with the telling of a chronological collection of events in a structured way. The stories revolved around a purpose, though this purpose was not the same for each storyteller. These stories contained lots of evaluation and reflection that worked to interpret and contextualise the emotional experience of events. Within the stories, there was often more than one plot present. Each 'sub-plot' was characterised by a crisis point or complicating action, that was then pulled together into a coda clause. This multiplicity of plots, of stories within stories, made the structural classification difficult at times as the primary function of the clause was not always clear. However, to mitigate the risk of losing vital context by the use of Labov & Waletzky's strict classification, I employed a more fluid analysis style that continually returned back to the overall story that married the sub-plot narratives together. This ultimately led to the realisation that an additional analytical tool was needed that would look deeper than the structure of the text, to hear the multivocality apparent within the stories. However, I felt the structural component of the analysis to remain valuable as it had furnished me with insight as well as direction for further enquiry.

4.1.1 The Abstract Clause of the Story

The first structural element of Labov & Waletzky's (1967) framework is the abstract clause. This clause is described as reporting the entire sequence of events of the narrative. Within the data set, rather than summarising events, the abstract clauses set the shared context for the remainder of the story. It orientated the listener to the birth belief model of the woman telling the story and her subject position within it. This helps the listener to anticipate the journey of the woman either in the achievement of her expectation or in her experience of its disruption. The birth belief model of the woman was reflected in the expectations she presents for the birth. For example, Elizabeth describes:

> "I had planned to have a home birth from the very start of my pregnancy. At 40 weeks I had had enough after having labour pains for 2 weeks. I had 20 chicken nuggets and a bottle of castor oil. The labour started within 20 minutes"

While Elizabeth states her birth expectation in the first sentence, the remainder of the abstract sets a context of confidence and control implying achievement of her expectation at the end of the story.

Dania also states her birth expectation and belief model as she makes an effort by transferring out of her area to pursue a natural water birth experience. However, within this abstract she intimates not achieving her wish as 'nothing went as planned':

> "1st baby, nothing went as planned but overall a magical experience. I transferred to a hospital a little out of my area to have a natural water birth experience, despite being in pain with SPD."

Alison's abstract infers her belief model to not be the highly medicalised outcome she experienced. Furthermore, her sentence about the midwife suggests an expectation of a less caring relationship from the birth attendant:

> "Although I ended up with a section I had a beautiful birth experience, the midwife was amazing, she was kind, thoughtful, caring and made me so at ease" (Alison)

All three of these examples orient the reader clearly to the starting point of the woman in her story and set the tone of what will follow. They are mirroring an anti-medicalised birthing discourse and emphasise the personal effort of the woman to achieve a 'natural birth experience'. Elizabeth plans from the beginning to birth at home, Dania transfers out of area for the natural birth she desires, and Alison still manages a 'beautiful experience' despite the medical intervention. These women are performing determination and alignment to a birthing discourse, from the opening sentence of their story. Already, the expectations of the forum audience, or the perceived dominant discourse of 'natural' is best is apparent. Even though Alison gave birth by Caesarean section, the characteristics of the attending midwife she describes as contributing to her beautiful experience, imply a shared understanding of what a non-medicalised birth looks like. Within these 3 examples there is a feeling that control and nurture are important components.

Other stories, whose authors either do not want or do not achieve the 'natural' outcome, use a longer abstract clause to situate themselves as in control of their alignment with a medical approach to their birth experience. For example:

> "…throughout the pregnancy I had gestational diabetes so they weren't keen to let me go any longer than my due date and I was pleased…it also took away the anxiety of is it starting or isn't it so I agreed to be induced as petrified as I was" (Gemma)

Gemma's abstract illustrates 'they' as the medicalised institution making decisions about her body. Her description of suffering gestational diabetes acts as legitimacy for their involvement as her body and pregnancy required medical monitoring to ensure a safe outcome for Gemma and her baby. In her reassurance to the audience, that she was

pleased as it took away the anxiety associated with the unpredictable onset of labour, she performs control in her medicalised pregnancy.

In contrast to this situating of the storyteller as in control of their alignment to a medical approach is the abstract from Kelly's story. She sets the scene by describing her daughter's presence as astounding. Already the reader is aware of some dramatic or complicating events to come. She alludes to her vulnerability when she presents her medical diagnosis as the authority in her birth and her position as subordinate to the monitoring process it brings. Her assumption of shared perspective in her audience that medical recommendations are binding and not negotiable is clear in her use of the word 'compulsory' when describing the monitoring regimen. However, the use of this word in her abstract is also a symbol of resistance. Kelly's alignment with a medical discourse of safety in the face of her bodily dysfunction is a reluctant one that changes to a source of anger through the momentum of her story as expectations of control and relational connection slips away from her.

> "How our DD is here at all is somewhat short of astounding. I was diagnosed with pre-eclampsia after 6 months of pregnancy…along with it came the compulsory visit and check up at the hospital on a weekly basis and monitoring" (Kelly)

Already it is clear that there is a shared understanding between the storytellers and their potential audience of the dominance of the medical birthing discourse, and that determination is necessary to pursue the characteristics of control and relational connection associated with the natural birthing discourse assumptions of the storytellers. The storytellers state their birth belief model at the beginning of their story to orient the audience to the direction and message of their story. From these 5 story abstracts, messages of control, resistance to the medical birthing discourse and advocacy for the natural birthing discourse is evident.

4.1.2 The Orientation Clause of the Story

The function of the orientation clause in the stories is to orient the listener to the context of the story and includes details such as time, place, people involved and their behaviour (Labov and Waletzky 1967). Orientation clauses occurred throughout the stories of this project, reminding the audience and relocating them to the events of the story. A significant proportion of the story tellers used the details within the story's orientation as a defence of their response to their birth. This defence was characterised by either their inability to act on bodily messages (6 stories), or of not meeting their birth expectations (4 stories). Both of these threads suggest an assumption among the storytellers of shared but unvoiced

expectations in birth with their perceived audience. This is accompanied by a sense of shame in the face of perceived judgement from others about not achieving the shared ideal e.g. not in a toilet (Tammy), with the support of a partner (Felicity and Emma), without medical directives (Dania, Suzanne), or that the woman knows how to interpret the birthing messages of her body (Claire). The behavioural justification is framed within emotive storylines, mediating between the body, emotions and lived experience and adding emphasis or credibility through the language of drama. In light of this, I felt the defence narrative was therefore against these shared but unvoiced expectations of birth presumed to be shared by the audience whose presence was introduced in the analysis of the abstract clause.

4.1.2.1 Bodily messages

Bodily knowledge of birth encapsulates the pre-reflective experience of being in labour and of following your body through its different cues, enacting the body, until birth is achieved. The assumption that birthing women can listen to and interpret the cues of their body is revealed by the presence of a defence as to why that knowledge or ability was not present in the reported birth experience. Sometimes this defence took the guise of blame. For example, blame may be projected onto the midwife for an action as the story teller was not aware of the bodily message as in Tammy's birth experience:

> *"*I had the sudden urge to go to the toilet, they stupidly let me go. On my own sat on the toilet the midwife came to check me, Her face was a picture, She told me she could see babies head and I would need to walk to the lounge to give birth"

Tammy was helped off the toilet and baby arrived 5 minutes later in the bathroom. Unrealistic levels of interpretation appear to have been expected of the midwife by Tammy for the conduct of the birth as this defensive statement puts the blame for the unexpected outcome of birth in the toilet on to 'them'. Her reference to the midwives as 'they' further emphasises the separation Tammy feels between herself and her birth attendants at that moment.

The birth story of Suzanne also moves blame towards 'them' for the direction her labour took. She ends up having an emergency caesarean section and states how,

> "My energy was starting to go though 'cos of being an older mum (over 40),
>
> And the nurse says it's always a pity mums aren't allowed any food, as a bar of choc would really help mums along!

> My labour wasn't progressing so they decided to give me some Oxytocin to help the labour along. I had specified on my birth plan that I didn't want it as some people can have a bad reaction to it but the nurse said it was a 'one in a million chance' and so reluctantly I agreed. My drip was hooked up to the oxytocin and straight away it started to impact on my baby's heartbeat"

The midwife's awareness of the need for nutrition and hydration to sustain a woman and augment the progression of her labour is voiced but the institutional narrative of augmentation with oxytocin holds greater authority. This subversive comment by the midwife and its place in the story of Suzanne stands in solidarity with the efforts of Suzanne to experience her birth outside the interventions of the institutional narrative. Perhaps it is this sense of solidarity that prompts Suzanne's reluctant agreement to finally accept the oxytocin in conversation with the midwife in contradiction to her birth plan. This agreement comes in a context of extreme vulnerability, of tiredness, hunger, pain and search for support and direction, yet Suzanne presents it as her decision, in the same way that she accepts her failing energy as a result of being an older mum.

Mother of three – Claire – neatly illustrates a lack of bodily birth knowledge by justifying her presentation at hospital in unknown and advanced established labour with all three of her pregnancies by appealing to the medical caveat of the unpredictability of labour:

> "My labours were all different! With the first baby I had to get induced so never had contractions on my own so when it was time for baby number 2 to make an appearance, I convinced myself I just had bad wind and it wasn't labour when my 3rd labour came along I had incredible lower back pain as I suffered from lower back pain in all pregnancies, I put it down to that. You would think with 3 labours I would have known but shows you how different each one is."

In these illustrations, either a lack of belief or an inability to interpret messages of the birthing body against the institutional narrative resulted in a lack of agency and disappointment for some in the unfolding experience of the birth. This theme is expanded in the thematic analysis section under the category of 'White Noise'.

4.1.2.2 Unmet birth expectations

Unmet expectations of support during birth were those held by the storyteller and introduced to the reader alongside the belief model in the story abstract. Within Emma's story, she orientates the reader to the context of the story drawing on details of time, place, people and behaviour:

> "Contractions woke me up at 1am, and I woke my (ex) husband to let him know. He informed me that he needed to go back to sleep and did so for the rest of the night. Yep there's a reason he's the ex. A lone first labour is a daunting thing."

It is within this context that Emma then shares her birth belief model which underpins her expectation for the birth:

> "…the big plans I had for a water birth and just gas and air. I was disappointed to find I didn't enjoy sitting in tepid water, and the gas and air just didn't work for me. I gritted my teeth until midnight then begged for an epidural. Oh my, what a friend indeed. After the loneliness and pain of the first part of my labour, this was bliss."

She justifies her change in direction towards a medical birthing discourse by accessing the shared birth expectations between the storytellers of this project and their audience as revealed in the abstract analysis. The experience of control and nurture are evidently missing from Emma's account by her reference to loneliness. The image of a water birth commonly involves support, togetherness with a birthing partner, calm and relief of pain by the water. As the support structure for Emma was missing, the water and the environment consequently did not support her to enact the birthing body as she had expected. She uses this to justify her search for support from technological sources, the antithesis of this water birthing ideal.

Dania states her birth belief model in the abstract of her story as she describes transferring to a hospital outside of her area to have a natural water birth experience. She ends up being induced but shares her continued eligibility to use the birth pool for pain relief. This context stimulates her need to present a justification clause as she goes on to accept the siting and commencement of epidural analgesia. She projects the reason for her deviation from her expectation of a natural birth on to her medically legitimated condition of SPD as opposed to her inability to deal with the labour contractions. This shows the discursive hierarchy as the medical narrative is prioritised as an explanation for the situation. In this way, Dania manages to maintain her birthing status within her compromised birth experience:

> "I had gas and air throughout the water breaking although will stress that it was not painful. Despite this and the pessary my contractions remained irregular so I was advised to have the drip, and an epidural (not so much for the contractions, but for the need to be on my back further aggravating the SPD)."

These two examples of justifying how the storyteller has not met their birth expectation can be further interpreted. In both examples, the expectation was related to the enactment of the body in labour. As the concept of embodiment reflects the interaction between context

(physical, sociological and psychological) and the material body, these storytellers share the disruption they have experienced in the communication of these two domains and their turn to alternative support mechanisms and models of enacting the body in labour. They continue to perform control and agency within their story, presenting the move to biomedical support as their decision following consideration of circumstances outwith their control to amend. They position themselves as autonomous decision makers, challenging the malfunctioning body or inability to cope accusations that often accompany medical intervention in labour from critics of the model. However, the linguistic framing of their justification suggests a defence, rather than a confident self determined statement of fact. The emotion of the exchange introduces ambiguity, suggesting the storyteller feels caught between two opposing discourses (Chadwick & Foster 2013).

4.1.3 The Complicating Action Clause in the Story

The next clause in the structural analysis framework of Labov and Waletzky (1967) is the complicating action. This classifies the main body of the story where the narrative unfolds. Within the main body of the stories of this project, I found a similar functioning clause to that labelled during the work of Labov & Waletzky (1967) with young men in the challenging neighbourhoods of 1960's New York. They named this a 'Protest Event'. Within the context of this project, the 'protest' was found to occasion as a restoration of agency within the birth experience through enactment of the body. The protest event emphasised the agency of the storyteller and drew on different storylines; strength of the woman (Alison, Gemma, Kelly, Lissa, Nicole, Sophie, Wendy); and listening to her body (Andrea, Amber, Cindy, Elizabeth, Maryline). This restoration of agency was against the control imposed by the institutional culture and its impact on the conduct of the birth. The protest event acts as a turning point in the story, often following a period of personal uncertainty and reflecting the ascendancy or confirmation of embodied knowledge, reconnection with and enactment of the body in labour.

For example, Cindy had planned a homebirth with her second child but progressed through labour too quickly for the midwife to attend. She and her husband were guided through the birth by a 999 operator and an ambulance was dispatched in case of the need for emergency assistance. Cindy's protest against the pathologizing of unattended birth and the consequent institutional response uses lots of body-based metaphor, reflects her belief in the natural birth model and confidence in herself:

> "Now I'll spare you the details but no-one reached us in time. My husband delivered our daughter with the 999 operator on speakerphone. It was surreal, terrifying and

> exhilarating all at the same time. The next thing I remember is the operator saying congratulations and there should be a paramedic at the door…[there were]…6 medical professionals in total and a queue of blue lights and cars stacked down my road in case they were needed. They weren't."

Following the drama and build-up of the story, those two words 'They weren't' speak volumes to narrate her strength and position her in control of her body and her birth.

Another example is seen in the story of Andrea:

> "…once my waters had broken the nurse sent my OH [Other Half] home! I told her I didn't think it would be long and called him to come back while I had a bath. I got out of the bath and was examined. They said I was fully dilated and needed to go to the labour ward"

Andrea's bodily knowledge was confirmed by the measurement procedure of the institutional narrative that granted her access to the labour ward and the continued support of her husband. Amber has a similar moment of clarity as her body in labour connects to her self following a period of uncertainty and dependence as she enters the hospital and waits to be examined. This examination is the ritualised gateway to accessing the birth pool and 'gas and air' support she wishes for her labour. Amber uses her body to frame her protest, creating a storyline in tension to the institutional narrative of compliance and dependence, by taking an unconventional birthing position of all fours in response to her interpretation of what was comfortable for her body.

> "Eventually I got moved to the birthing pool which my partner got in with me. I kept falling asleep as I was exhausted at this point and got out. I just couldn't get comfy!! After what seemed like forever I knew I needed to push my little girl into the world…I found a 'comfy' place for me to give birth and of ALL the places it could have been; it was on the floor on my hands and knees as if I was crawling"

Embodiment and agency come together in these experiences as the confidence of the woman interpreting her body in labour stimulates confident, definitive moments of control as she utilises the environment in communication with her body in labour. Her body based descriptions call on the mirroring capacity of the audience to understand the bodily actions performed in the story through activation of their own bodily sense of performing the action.

The example of Maryline underlines her agency in the birth through an unfortunate atmosphere of conflict. She also uses her body to frame her protest against the dominance of the institutional narrative symbolised by choice of birthing position and vocalisation. Her

embodied telling shares her experience of the power in labour and her reflective articulation of her body;

> "The interventions of numerous monitoring machines did nothing to reassure me or make me comfortable, and the gynaecologist was far from understanding but I was determined to fight my corner and avoid an epidural if I could manage it and choose the position I was most comfortable in (for me, standing up at the beginning then on all four), Obviously the monitors did not work properly, And I was told until the actual birth of my son, That my contractions were not sufficiently efficient and that it could take a while…Looking at my suffering my husband had left the room…I was screaming and not being at my best at that time but this was only to announce that the baby was truly coming"

The 'protest event' within the main body of the stories was found to occasion as a restoration of agency within the birth experience following a period of uncertainty or dependence. The storyteller uses her body in communication with the environment to exact a protest against the master narrative of the institution and its prescribed controlling rituals of birthing bodies (Krook 2007). The body-based descriptions of the storytellers invite the audience into a kinship of protest through activation of their own bodily sense of performing the action (Ellingson 2017).

4.1.4 The Evaluation Clause in the Story

An evaluation clause provides information on the consequences of the narrative event for human needs or desires (Labov & Waletzky 1967). From the story excerpts used already it is clear that evaluation clauses were peppered throughout the stories. They acted as reflective input as they were not contemporaneous, more often styled in an 'aside' to the audience. These have the function of turning physical events into an experience that conveys meaning, acting to emphasise the reflective construction of narrative meaning from physical and emotional experience. This has been built from carefully chosen components to represent the experience and build the account. An example is taken from the story of Alison:

> "…even though I needed a section (ella's heartbeat kept dipping) the care they gave me to make sure everything was okay was amazing. I never felt any fear as they had everything under control. My midwife was called Anna"

The evaluation of her feelings in the reconstruction of her story shows the trust she had of her birth attendants, specifically the midwife she names at the end of her narrative and consequently that everything was amazing. This is in addition to the sense of calm she

expresses through the birth. This apparent satisfaction with her birth is perhaps related to her handing control to the birth attendants and consequently the unpredictability and unknown of birth is removed. By stating that she felt no fear, she hints at her pre-birth expectation of being afraid and that handing control to the birth attendants was legitimised by this fear in contrast to the prevailing impression from the storyteller's that the natural birth discourse should be the ultimate aim. Alison reports achieving the relational support from her midwife which was maybe the priority need for her as opposed to physical orchestration of events.

Lissa's birth story contains a comparison between the birth of her two children. The first experience is similarly described as amazing and is linked to Lissa feeling calm and in control. In this story, it is Lissa herself who feels in control during the birth rather than handing this responsibility to the birth attendants. These characteristics fulfil her pre-birth expectation of the experience, with positive evaluative results.

> "Had DS [dear son] about 4 hours after arriving. The cord was round his neck so needed rubbing slightly but was fine. Loved his birth. Felt calm and in control and it was totally amazing! DD [dear daughter] was born 40 minutes after arriving at hospital and pushing for 11 minutes! Very quick and was quite overwhelmed this time, maybe cos it all happened so quick".

Lissa describes her daughter's birth as very quick, this is in comparison to her first birth experience. She describes herself as feeling overwhelmed. As an evaluation clause aims to report the consequences of the narrative event on the needs or desires of the storyteller, the speed of birth suggest a need or preference for a slower transition. A slower transition time from pregnant woman to separation of the child and renewal of the mother identity is perhaps preferred to allow for emotional and social adjustment to the change. The liminal experience of labour, where the storyteller moves between bodily states, is a highly emotional and vulnerable experience as she is subjected to lots of messages and learning about herself, from her own interpretation of events and from the responses of others. Consequently, a lack of time to process this information could lead to her feeling of being overwhelmed.

Despite this admission of vulnerability, or even because of it, Lissa goes on to perform a position of strength and endurance by her minimal use of pain relief, both characteristics encouraged within the natural birth discourse. She emphasises her stoicism by reminding her audience of the agony of contractions. Her evaluation is made more powerful by sharing her experience of pain after the birth of the child. The third stage of labour is rarely mentioned in the stories as if the bodily experiences of the storytelling woman fade to the

background in the face of the new baby's arrival. This experience has clearly impacted her significantly as she shares her traumatic evaluation though keeping the details to a minimum. This could be for the social sensibility of the audience or of her inability to relive the experience in too much detail due to the intense emotions still connected to the memory.

> "Both times only had gas and air. With DD though, her placenta would not come away so got blue lighted to another hospital cos I was losing a lot of blood. Still contracting, agony! Had to have surgery to remove it and a blood transfusion. So, birth perfect, if a little quick and intense, afterwards all too traumatic!"

Felicity also had a very fast birth that left her scared and traumatised.

> "I was left…it was without doubt the most scary, traumatising event of my life. I was all alone, apart from the midwife (and all the other ladies on the ward, just outside the toilet) and I didn't know what was happening"

She felt alone despite the physical presence of others around her. Felicity also describes her experience as traumatising. This word transmits a disturbance accompanied by hurt and grief in a context of shock. The deep emotional impact of the disrupted expectation is encapsulated in this evaluation. In addition to the swift and unexpected birth is the feeling of being alone and not knowing what was happening. Despite the presence of many people, Felicity did not express a connection with anyone, showing support to be more than just physical presence. The absence of positive birth characteristics such as nurture, relational support and control are compounded by the speed of transition through the liminal phase of birth leaving Felicity physically and emotionally impacted.

4.1.5 The Resolution Clause in the Story

The resolution of the narrative is the set of actions that follow the most reportable event. Within the birth stories of this project, the resolution or outcome of the plot was action oriented, recording the achievement of the woman, even if it was negative:

> "You would think…I would have known" (Cindy)

> "Currently ttc [trying to conceive] no3 so hasn't put me off" (Lissa)

This functional focus of the resolution clause emphasises the role of the woman as the central actor in the birth experience. Even if the resolution clause contains the birth of the child as the outcome, the achievement and contribution of the woman to that event is clear. The success of the woman is emphasised through the bodily characteristics of weight, health and beauty in the child:

> “She was 9lb 5oz so was my heaviest and quickest” (Andrea)
>
> “…my beautiful daughter” (Cindy)
>
> “I had a healthy baby boy…” (Elizabeth)
>
> “…pushed our beautiful baby girl out weighing a lovely 9lb 1” (Kirsty)

Other stories use the outcome as an opportunity to perform strength. This quality is expressed through spatial movement metaphors, using the context as an opportunity to express a characteristic that is not usually socially celebrated in women:

> “The midwife could not believe it from waters breaking to baby coming it took about 4 minutes” (Elizabeth)
>
> “I managed to keep him there until I saw my husband pop his head in the door then with one push he was out.” (Gemma)
>
> “…the strongest feeling was empowerment: in spite of everything, I had remained confident I could do it in the way that I felt was the best” (Maryline)
>
> “I went from three centimetres dilated to fully dilated within 20 minutes” (Rebecca)

Taken together, they perform an identity of strength, again reinforcing the woman’s authenticity of gaining entry to the nebulous ‘mothers’ club’. Amber takes this finding a step further with her resolution clause:

> “I can’t imagine my life without her and she completes me”.

She positions herself in a well-known contentious stereotype, confirming a woman’s need for a child to be complete. This project is unable to explore theories of motherhood, and merely presents this finding as evidence to inform the proposition of assumed characteristics of a dominant mothers’ group.

The resolution of the stories is overwhelmingly action oriented, using enactment of the body to position the storyteller as the central actor in her story. The body is again used by the storytellers, this time through the use of spatial movement metaphors, to perform an identity of strength. This positions the storyteller and her experience as authentic in her bid to gain entry to the nebulous ‘mother’s club’.

4.1.6 The Coda Clause in the story

The coda returns the listener to the present from the world of the story to the world of the storytelling event (Labov and Waletzky 1967). Reconstructions of events are influenced by

how things are now, and the coda gives an insight into this current context of the storyteller. Sensory impressions are often stored quite accurately with the assembly of the events changing according to the demands of the present to ensure the emerging storyline fits with the needs of the self (Fernyhough 2012). For example, in the stories of this project, the needs of the self are revealed in the storyteller's plan for their future birth based on their experience of the storied birth:

> "Would love to do it in a pool if I'm lucky enough to have another one! Xx" (Lissa)
>
> "I would absolutely make sure I got the epidural next time (if there is a next time lol) x" (Nicole)
>
> "…this has encouraged me to have a home birth next time as I felt very rushed and not very well listened to in the hospital setting" (Maryline)
>
> "I am now the proud mum of a 12 year old girl and nearly 5 year old boy, and that's me done!" (Emma)

Other storytellers share the force of coherence in the story to fit with the needs of their self to be 'back to normal' or undisrupted by the magnitude of the life change associated with birth. This could express performance of a coping narrative by positioning the storyteller as only minimally inconvenienced by the birth event:

> "I had a perfect 6lb 11oz baby in my arms ~ just a shame she couldn't have waited a couple more days as I'd originally booked myself in for a pregnancy photo shoot for the next day!" (Wendy)
>
> "My baby boy was born swiftly after all this, and all I could think during the last few minutes of labour was that our car park ticket had run out and we would get a massive fine! When he arrived, he was placed on me, and my first words were, 'ooh a baby!'" (Sophie)
>
> "We were kept in for several days to be monitored. The same monitoring that got me here in the first place! We are both well now and Mia is 6 months old and thriving." (Kelly)

In contrast are the stories that shared a negative birth experience. Some, like Lissa's hinted at a difficult experience but the coda framed the story in a positive context. Those with a negative coda, like those of Suzanne and Felicity, were reflected in the graphic detailed emotional style of the account, reliving the birth experience from the inside. Their coda sets the negative tone of the story and acts to pull them back to the intervening demands of the present:

> “It was only when I was packed and ready to go that a nurse came and chatted to me, but by then I was so cheerful and low, no-one could persuade me not to go home. That was 10 years ago now. My beautiful baby is now growing up. But nothing can take away the sadness of the aftercare experience. This was at ## Hospital. Maybe things have improved now? I hope so!” (Suzanne)

> “My first birth was 7 hours and I was pushing for 50 minutes, so this was not expected. All is fine now though. My baby is a very good size and physically I’m all healed, mentally not so much” (Felicity)

The coda reveals the emotional context of the story as the events have been reassembled according to the needs of the present self. Two examples dominate in the stories of this project. Either the coda is positive and looking to the future that suggests a sense of coherence has been achieved by the storying of the birth, or sharing the current position of the storyteller suggests there is need of the self to heal from the birth experience. This need for healing is reflected in the highly detailed, emotional reliving of the birth from the inside.

4.2 Thematic analysis

Thematic analysis is characterised by searching repeatedly across the data to find patterns of meaning. Analysis of these patterns allows wider theorising about the socio-cultural conditions and structural conditions enabling the construction of the data (Braun & Clarke 2006). Within this project, the theoretical literature was accessed following construction of a thematic map from the data. This was then revisited in light of the theoretical suggestions, resulting in further interpretation and refinement to present four interconnecting themes that encapsulated the embodied telling of birth vulnerability and strategies used by the storyteller to negotiate her identity. I have named these themes as: (1) White Noise (2) Doing the body (3) Bargaining Authenticity and (4) Witness to Transition. In line with Reissman's (2008) approach, narratives were then selected to illustrate the developing theoretical arguments emerging out of the analysis and the connection between personal stories and larger social concepts.

4.2.1 White Noise

White noise is created by frequencies equally distributed over the whole hearing range and is often used therapeutically to mask irritating or background noises. Within the context of this project I use it to describe the masking sound of the controlling institutional narrative that blocks out potential counter narratives. The particular silenced narrative of interest to this project is the agentic birthing woman directing her birth experience. I found potential for the institutional narrative to sow doubt in the mind of the woman by crowding out her interpretation of her body in labour, but it also acts to potentially silence the experience of the labouring women from the perspective of the attending birth workers or midwife.

Gemma's story portrays a lack of confidence in listening to her body in labour against the feedback of the midwife:

> "I went in on Saturday morning to start getting prepared and by Saturday night things hadn't really progressed. My husband was told to go home and get some rest and that I would more than likely be induced in the morning.
>
> That evening I started to get some discomfort and was reassured it was normal, so I took some paracetamol and tried to go back to sleep. Obviously, I couldn't and kept pestering the midwife to ring my hubby but she was adamant they wouldn't ring him until I was in labour.
>
> If this isn't labour I don't think I can cope with it I was thinking to myself but thought they obviously know best and perhaps I wasn't in labour after all.

> I kept complaining of leaking down below and they didn't make a lot of that but the pains were getting strong, I managed to get in the shower and back down the hallway, I jumped back onto the bed with the help of the midwife when I heard a POP and I may have not bothered with that shower as my waters popped everywhere.
>
> The midwife was happy to examine me then as the waters had gone and she looked up in shock and said you're 10cm dilated! I remember saying "what does that mean then",
>
> "you're having this baby now" she replied. All I could say was "my husband, what about my husband",
>
> "we're phoning him now" was her response."

As Gemma was unable to sleep and asked the midwife to call her husband, this could be an example of her body preparing for labour and seeking the safety and support of her husband. This support could be to allow Gemma to give her body in labour precedence over her thinking self, and for her husband to act as witness to her transition in this role within the birthing ritual. However, her understanding of her bodily feelings was suppressed by the power of the institutional message. This is to the extent of doubting her body and her capacity, assuming the midwife knew better than Gemma if she was in labour.

Gemma's story progresses swiftly through her spontaneous rupture of membranes and transfer to a delivery room in the bed with 'gas and air'. In the concluding stanza and climax of Gemma's story she re-joins her body in labour, willing her baby to wait until her husband arrives, yet without the confidence of belief in her embodied experience, or perhaps in the shared understanding of her audience as she explains:

> "In the delivery room it sounds silly but I was squeezing my legs together thinking please don't come out baby boy. I managed to keep him there until I saw my husband pop his head in the door then with one push he was out!"

In Amber's experience, she arrives at the hospital after coping at home for a number of hours. Feeling that her labour is progressing she and her partner transfer to the hospital, focusing on the support she needs to increase her comfort and sense of safety. However, Amber portrays the institution as most concerned with assessing her labour progress and consequently sowing doubt into her mind. She moves from a confident birthing woman to doubting her ability to cope:

> "I decided to go see my partner as it was Valentines day and surprise him after work. Once he came home I kept telling him that these back pains were very strange as

they came quite often (like every 15 minutes) – didn't once occur to me that it could be labour until his mum said. So that was the beginning of my labour.

My labour started to really hurt on 14th Feb at around 9pm. My Mum had picked me and my partner up to take us to hers so we were closer to the hospital. I'd been in slow labour since 6am and was already exhausted and just wanted to sleep!!

At 2am after dancing around the house from being in pain I decided I couldn't take it any longer and needed to go in to hospital for pain relief.

Once I got there all I could hear were women screaming in pain. I turned a ghostly white and just sat down and shut up – the midwife told me not to panic and that the women were in a lot of pain from pushing.

I've never been so scared in my entire life!! I didn't know what to expect now. There were women screaming, I was panicking because they were screaming, it was my first baby so I didn't have a CLUE what to expect.

I asked for gas & air and my birthing pool but got told I had to wait until they examined me before they could really do anything. When they got round to examining me I got told I was only 3 cm. My first thought was – ONLY 3CM AND I'M IN AGONISING PAIN, HOW CAN I PUT UP WITH THIS FOR MUCH LONGER!!!" Amber

This preliminary assessment on arrival by the midwife will determine if Amber is in active labour and therefore eligible for use of the birthing pool. Women can experience the latent phase of labour on and off for days in some cases and management of latent labour is very different from active labour. If a woman is deemed to be in active labour and not progressing to parturition, interventions are instigated to expediate the birth of the baby. This can range from augmentation of contractions with medication to instrumental delivery or caesarean section. The risks and costs of intervention must be carefully balanced with the well-being of the mother and child, hence a number of restrictions that could be perceived as barriers by the birthing woman. But the culture of focusing on the cervical dilation number as a marker of active labour can create doubt and stress in the birthing woman as is shown in both Gemma and Amber's stories. The physiological impact of stress hormones on the minded body's progress through labour is well known to disrupt the natural ebb and flow of its rhythms, emphasising the importance of institutional reception to support the equilibrium of the body in labour.

The White Noise of the institutional narrative has been socially reinforced by various media as is shown in the story of Wendy:

> “I can remember sitting on the sofa watching tv when I suddenly started getting tummy pains at 2300. Honestly speaking, I thought it was from the dodgy tofu that I'd had for dinner
>
> as it had gone slightly off in the warm June days of 2011 ~
>
> It wasn't until I got to the toilet that I'd seen I had a "show" ~ I kept getting tummy ache and had to go to the toilet ~ my husband insisted I called up the hospital at 2330 and the midwife told me that some ladies get a "show" and don't actually have the baby for 2 weeks! She told me to call back if the pains got worse or if I was concerned with baby's movements.
>
> For the next hour and 15 mins I was walking back and forth from the bedroom to the toilet (as it felt like I needed a huge poo!) ~ I would be asking my husband to rub my back one minute and hitting his hand off me the next ~ bouncing on an exercise ball for a minute then crouching over the bed the next ~
>
> During this time my husband kept asking me whether I wanted to call labour ward and every time I said no ~ I didn't want to be one of those women I'd seen on OBEM that got sent home!
>
> It wasn't until I finally looked at the clock to monitor my contractions that I noticed they were coming thick and fast ~ once every 3 minutes! So I called up labour ward again and they told me to go in and get checked ~” Wendy

(*OBEM – One Born Every Minute. A British reality television show based in a labour ward of an English hospital).

Wendy’s fear of humiliation, by being sent home when not in active labour, originates from institutional messages relayed and reinforced through an ‘entertainment’ programme on television. To be sent home early because of not fitting the admission criteria of the institution suggests the woman’s experience is not worthy, discrediting the validity of her experience.

A similar interpretation of potentially not meeting the institutional criteria and being held as not worthy of admission, created white noise in the labour of Kirsty. Her preoccupation with the lack of response from the institution when she called because her waters had not broken and the fact that she could speak through contractions resulted in a fixation on the need for her waters to break before she could gain access to the institution. This is despite the increased frequency and intensity of her contractions in this her second labour (commonly much swifter than the first birth):

> “Because my waters hadn’t broken and I could talk through my contractions they told me there was no rush.
>
> A mistake to listen to as the pains kept coming and still no breaking of the waters. I decided to set myself a bath and call my mother in law to collect my sons. The time was half past 4, the pains were 10 times worse and still no waters”

She displays classic shame behaviour as described by Brown (2010) as she asked for help and was denied on her terms. Her withdrawal or keeping silent results in an unscheduled birth at home. Although this is an unusual conclusion, the stories of Amber, Wendy and Gemma share Wendy’s characteristics of a shame response where the institutional narrative has impacted the minded component of the woman and muffled that of the body. On the institutional side of this interaction is the midwife who reinforces the institutional narrative rather than foregrounding the learning that every labour experience and the woman’s response to it is different and very individual.

4.2.2 Doing the Body

Doing the body in labour was storied in all the narratives. Its presence was subtle in its emphasis by the storyteller and rarely acknowledged. Instead there was a focus on either the action or consequence of the doing body to keep the story flowing. It presents in two distinct forms that were not necessarily exclusive: re-joining of the minded body in labour and the interpretation of emotion through the body’s response to the environment. Firstly, is the re-joining of the self and body in labour where the subtle messages of the body break through the ‘white noise’ of the institution. This re-joining symbolises confidence in the woman to interpret what her body is telling her. For example, in the story of Andrea:

> “My last one was after a 9 year gap, and like the other two I loved being pregnant. I went into hospital for a few days as the heartbeat was slow and once my waters had broken the nurse sent my OH home! I told her I didn’t think it would be long and called him to come back while I had a bath. I got out of the bath and was examined. They said I was fully dilated”

This realisation of the minded body was most commonly in relation to an overwhelming urge to push during the second stage of labour. It often created a climax in the story of those women who experienced the sensation. For example, in the stories of Amber and Kirsty:

> “Eventually I got moved to my birthing pool which my partner got in with me. I kept falling asleep as I was exhausted at this point and got out. I just couldn't get

> comfy!!! After what seemed like forever I knew I needed to push my little girl into the world…I found a 'comfy' place for me to give birth and of ALL the places it could have been; it was on the floor on my hands and knees as if I were crawling!
>
> After an hour and half of pushing and a 16 hour labour my gorgeous girl was born at 13:26 on the 15th of February 2013." Amber
>
> "I couldn't go anywhere I had the sudden urge to push the time now being 5.20 the pain was awful and with no pain relief they was nothing I cud did my partner rang the ambulance and they were on their way I was laying in my bed on all fours with the urge of pushing and just my partner there to deliver our baby he was on the phone to the ambulance people the whole time" Kirsty.

Others expressed this sensation in a stronger way, emphasising its priority over socially defined rules of behaviour. For example, Wendy describes being examined on arrival at the hospital by the midwife in the following interaction:

> "On examining me the midwife said…'Okay Wendy, breathe through this next contraction' to which I screamed back. 'I CAN'T I WANT TO PUSH!!' And I did"

In contrast, some women storied a dissociation of the mind and body, either being unable to interpret the cues or not understanding how their contingent, labouring body works. For example, Elizabeth describes how:

> "While i was on the loo i felt baby i shouted for the midwife when she look my babys head was out and i was sitting on the loo. she told me to stand up or baby will end up down the loo but i was to scared incase baby shot "back up" slowley my hubby and the midwife eased my off the loo and luckly her hand were at the ready as soon as i stood baby came out she caught my baby boy"

And in the case of Claire;

> "my labours where all different! with the first baby I had to get induced so never had contractions on my own, so when it came time for baby number 2 to make an appearance I convinced myself I just had bad wind and it wasn't labour!
>
> I sent my mother a text to tell her how bad it was when I got a frantic call back saying 'you're in labour',"

A similar misreading of cues can be seen in the birth story of Sophie:

> “After a few hours in the waiting room, I was examined only to be told nothing was happening, but that as I was having some bleeding I may need to be kept in (actually I would have been transferred to a hospital 20 miles away as there were no beds.)
>
> Back to the waiting room I went, I started to get period like pains, and this being my first baby I just though they must be Braxton-Hicks, as they've told me nothing was happening! I had hour of to-ing and fro-ing from the toilet, telling my husband it was comfier on the toilet because "I needed to poo". When my husband heard this he ran and grabbed a midwife, and garbled something about me needing help! They got me out of the toilet and examined me and I was 10cm”

Tammy projects her inability to interpret her body’s message on to the attending staff, hiding her sense of inadequacy against the natural birthing discourse of responding to your labouring body with a blaming shame response:

> “At 17:30 another midwife came to see me and I again was in the bath at this point I told the midwife I just wanted to stay at home. I was then given the gas and air to breathe through the contractions, (whilst my partner sat on a chair half in the bathroom half in the hallway, watching despicable me on tele!!!!)
>
> I was then moved into the living room where I had the sudden urge to go to the toilet, they stupidly let me go. On my own sat on the toilet the midwife came to check me, her face was a picture, she told me she could see babies head and I would need to walk to the lounge to give birth.”

Doing the body in labour was also storied through the subtle interpretation of the woman’s emotion through her body’s response to her environment. This activation of her bodily sense of performing an action or ‘doing the body’ in response to her interpretation of body based intersubjective understandings is pre-reflective. This is because the body was seen to react to a stimulus only later interpreted and named by the woman when she had time to reflect on the full felt sense of the event. These examples connected feelings with meaning, in the form of a situational response, through the use of emotive language. This language is in contrast to the disembodied event reporting that used the technical language of medicine.

A clear example is evident in the story of Andrea:

> “My first baby was a three day labour…they had told me the baby was going to be around 12lb. I was terrified and I think I held off from relaxing into it, until I couldn’t do it any longer. She was 8lb 3oz”.

Andrea reflects on her corporeal response to the information that her baby was large, signifying the connection of this information to something beyond her, namely a learned assumption of difficulty or pain in labour with a 12lb baby. This socially derived knowledge is credited by Andrea as underlying her fearful emotion that ultimately restricted her labour.

Another example is taken from the story of Maryline:

> "I started having contractions on the day I was due, but they were irregular, they were on at times very strongly, especially at night, and then they would reduce in the morning to practically disappear. This trend lasted a couple of days until I felt they were getting stronger and needed to go to hospital.
>
> When we arrived, I was warned this could well be a false start and I could very well be sent back home, which I was prepared for.
>
> After a French midwife (although this was in a London hospital) examined me, my water broke and she decided I could stay in one of the rooms with the pool. She gave us advice about what we could do to encourage labour, and this was the best night I had since contractions had started.
>
> I could feel contractions getting stronger and being more efficient, but morning broke, and no baby in sight... The French midwife left, and was replaced by two midwives who were not as relaxed as the previous one. I could feel my contractions getting weaker as I did not feel as comfortable with these midwives as I previously did." Maryline

Maryline illustrates her environmental evaluation as potentially hostile with the less relaxed birth attendants and an experience of dominating power in the statement about having to get a drip [this would be to augment labour]. The quality of Maryline's birthing situation has clearly changed from the night before, spent with the French midwife. Her felt sense of the situation suggests a negative and threatening atmosphere and her body adapts to this intersubjective learning by slowing her labour.

Maryline goes on to share her bodily response to the degenerating situation,

> "The interventions of numerous monitoring machines did nothing to reassure me or make me comfortable and the gynaecologist was far from understanding, but I was determined to fight my corner and avoid an epidural if I could manage it and choose the position I was most comfortable in (for me, standing up at the beginning and then on all four).

> Obviously, the monitors did not work properly, and I was told until the actual birth of my son, that my contractions were not sufficiently efficient.... ??? and that it could take a while...
>
> Looking at my suffering, my husband had left the room... I was screaming and not being at my best at that time, but this was only to announce that the baby was truly coming.*"*

The emotion is heavy in this abstract of her story and the distress apparent from her non-conscious interaction with the negative birthing environment. Her use of the word 'but' verbalises a physical boundary or bodily hesitation, an internal resistance to the unsatisfactory anticipated situation of epidural insertion. The out of control feeling of her story physically pulls the reader towards the climax, letting them down before the anxiety becomes uncomfortable, to announce the impending birth. She rescues her anti-institutional portrayal of resistance behaviour through her reflection on the situation and reconnection with the positive symbol of the imminent arrival of her baby.

These two women, Andrea and Maryline, use emotional language to express their bodily response to their situation. Amber uses a similar style, sharing her intense emotion that precedes her overwhelming doubt. Fear and doubt manifest into the overpowering physical and emotional feeling of panic. The extreme language is visceral, it originates from her bodily interaction with the environment and impacts her response to the environment in turn as her knowledge no longer seems fit for purpose.

> "Once I got there all I could hear were women screaming in pain – I turned a ghostly white and just sat down and shut up – the midwife told me not to panic and that the women were just in a lot of pain from pushing. I've never been so scared in my entire life!! I didn't know what to expect now. There were women screaming, I was panicking because they were screaming. It was my first baby, I didn't have a CLUE what to expect"

The stories were full of embodied language in a style of engaging storytelling, reflecting the physicality of the birth experience, the sensitivity of the woman to her bodily interaction with the environment and context, and the appropriation of a language to share the experience of the birth with the forum audience. Stories often switched between this emotive style and a disembodied reporting of measurements that appropriated the language of the institutional birth culture. This switch signified crucial timepoints, for example in the 'diagnosis of labour', in the 'admission to the institution' and the transition to second stage and parturition. It is as if the emotive, physical experience of birth requires these technological anchors, from the

language of the dominant group of medicine, to legitimise the woman's transition between phases in the birth process.

4.2.3 Bargaining Authenticity

It was through the counter narrative of Nicole that the theme 'bargaining authenticity' was named. Initially I classified Nicole's story as standing against an acceptance of technocratic birthing. She sets the context;

> "…I had a normal birth which lasted 6 hours…I had some paracetamol when I first got there [but] couldn't have anything else to help with the pain. I am allergic to morphine and morphine derivatives"

She continues in her story by strongly justifying her lack of pain relief in labour as an inability rather than a choice. On further analysis it became clear that she had developed a defence narrative in solidarity with a perceived dominant group of women, to the extent of denying her original experience. Nicole perceives the other women in the postnatal ward may feel judged by her contrasting ability to birth without pain relief due to the observed interaction with the care providers. These women did not receive the congratulations and acknowledgement that Nicole's birth experience was attracting. Consequently, Nicole describes reframing her birth story to emphasise her extreme pain, desperation and even a desire for death. Her feeling of judgement from her drug free birthing experience results in a performance of suffering that she proposes is equal with women who accessed pharmacological analgesia. She has adapted her story to align her experience with her perceived audience and to protest against the professional judgement of women's experiences.

> "I am constantly getting responses from people like oh my word your such a hero! Your pain threshold must be really high. Wow well done for doing that. Even the midwives on the ward the next day were coming in saying wow you did fabulous for just having a couple of paracetamol.
>
> It's starting to really annoy me because I feel it's comments like this that make women who have loads of pain relief through labour feel like failures or weak. I was on the ward with 2 other women who had all the pain relief and no one made any effort with them to say "well done you!"
>
> I have started to respond to people by saying, no I am not a hero, I was in agony, I was screaming and crying for a c - section begging the midwife to pull him out of me

and Shouting for an epidural. It was so painful that If someone had given me the option to carry on or die I would have chosen death. It's only because I had no choice on pain relief due to the allergy and quick progression (jumped from 3cm- 9cm in 2 hours)

I hate that people see pain relief in labour as a weakness! I can guarantee you I didn't get a medal for it n I would absolutely make sure I got the epidural next time (if there is a next time lol) x”

This performance of suffering in response to a natural birth discourse emphasised the importance of endurance as a characteristic of the data set. I felt pain was perceived negatively by the women and status within the mother group was regained through its endurance. This view reflects a mechanistic perspective of the body as pain becomes a sign of the contingent nature of the body and in the controlled language of medicine; bodily failure.

The concept of endurance appeared to be used in two ways within the stories. Firstly, the woman’s endurance of a long labour was put forward as a justification for an undesirable act of intervention or ‘inappropriate’ behaviour within the story. Framing the conclusion in this way suggests subliminal acceptance of either the bodily failure narrative or internalisation of the female constraints imposed by a restrictive doing of the body discourse. This sub set of stories emphasised the extreme length of labour:

“My labour wasn't progressing so they decided to give me some Oxytocin to help the labour along. I had specified on my birth plan that I didn't want it as I had read that some people can have a bad reaction to it.

The nurse said that it was a 'one in a million chance', so reluctantly I agreed.

My drip was hooked up to the oxytocin and straight away it started to impact on my babies heartbeat, which went from 150 beats per minute to 16.

Straight away the nurse ripped out the drip and pushed the emergency button, and 4 doctors rushed in. The doctor tried to find my babies heartbeat and after a very scary couple of minutes of total silence in the room the heartbeat was found.

It seemed my baby indeed did have a reaction to the oxytocin. Then all carried on as normal for a while and babies heartbeat resumed, but later on as labour was still not progressing I had to have an emergency caesarean.

I was just thankful that I would be getting to see my baby at last as I had been in labour 39 hours.” Suzanne

And in the story of Maryline where she justifies her behaviour through an appeal to opposing discourses, the biomedical appeal to endurance and the natural appeal to the body vocalising the arrival of the baby:

> "I could feel contractions getting stronger and being more efficient, but morning broke, and no baby in sight... The French midwife left, and was replaced by two midwives who were not as relaxed as the previous one. I could feel my contractions getting weaker as I did not feel as comfortable with these midwives as I previously did.
>
> I was then told I would need to get drips, which I wanted to delay as much as possible. Another midwife examined my progress (quite violently dare I say) only to tell me that it was not possible that I had ever been at 7 (my theory is different about this, I think daylight, fear and worry actually blocked my progress, but God only knows....)
>
> I was then sent to a standard delivery room and managed to negotiate to get some rest and food before getting on to the next step.The interventions of numerous monitoring machines did nothing to reassure me or make me comfortable and the gynaecologist was far from understanding, but I was determined to fight my corner and avoid an epidural if I could manage it and choose the position I was most comfortable in (for me, standing up at the beginning and then on all four).
>
> Obviously, the monitors did not work properly, and I was told until the actual birth of my son, that my contractions were not sufficiently efficient.... ??? and that it could take a while... Looking at my suffering, my husband had left the room... I was screaming and not being at my best at that time, but this was only to announce that the baby was truly coming." Maryline

In a less emotional and more matter of fact tone is the endurance of Emma. What she chooses not to describe leaves a chasm of assumption about the emotional component of her experience disguised by her succinct delivery:

> "I was convinced birth would be quicker and easier second time around…well it was shorter. 31 hours instead of 32. Epidural and ventouse again" Emma.

The second thread in the use of endurance was to inform the status work of strength in the woman through her endurance of a fast and intense labour. This sub section of the data set carried a definite flavour of competition within the report of events:

“I waited in all the long queues, there was no seats available in the waiting area so I was standing in ALOT of pain, once again thinking it was purely the pressure on the hips that I'd had the whole way through!

my mum grabbed a nurse going past and said 'she's in labour' the nurse took one look at me and took me into my appointment and sure enough I was 7cm dilated and in fully established labour!

I was whisked into the labour ward with the hope my husband would make it in time! you would think with 3 labours I would have known but shows you how different each one is.” Claire

“…less than 3 hours after the first contraction pain my beautiful daughter was born” Wendy

“…3-9cm in 20 minutes” Nicole

“I was supposed to be having a water birth so the midwives was frantically trying to fill the bath so I could get in. It was a comedy show with the two midwives rushing round the room crashing into each other.

During all of this hubby had no idea I was about to give birth and was off fetching me some food.

They managed to fill the bath just as my waters broke and was ready to push. I got into the birthing pool just in time to start pushing and just as my daughter was about to be born hubby came bursting into the room.

Daughter number three was born within ten minutes. I went from three centimetres dilated to fully dilated within 20 minutes!” Rebecca

My own interpretation of labour pain is that it is a positive sensation and so should be described as a powerful sensation rather than carrying the negative, illness connotations of the word pain. In writing this statement I realised that this is what the midwives of Nicole’s story were sharing subliminally with the women in the postnatal ward. They were congratulating Nicole for fulfilling that natural birth ideal. With that comes an assumption of acceptance and personal control by the woman in response to the powerful sensations of her labour and resulting in no need for pharmacological support. Perhaps these stories of endurance are not just intra group competition to bargain their suffering as authentic admittance to the mother group, but also signifies inter group communication with the midwives, seeking validation for the authenticity of each individual experience.

Nicole's final sentence of the story suggests her need to fulfil certain criteria to achieve her rite of passage to motherhood, in the eyes of the mother group, to be stronger than her desire for validation of her strength from the midwives;

> "I would absolutely make sure I got the epidural next time"

This story lies in contrast to the findings so far that the birth stories of this project were framed for an audience that is perceived to believe in 'natural' birth as the ultimate goal, with any intervention seen as deviance that must be justified. The performance of status work through stories of endurance among those storytelllers experiencing an undesirable event would match this finding. Suggesting natural birth as a utopia to be aimed for but achievement requires defence to enable belonging to the majority.

4.2.4 Witness to transition

Two significant time points were identified in the women's stories where their vulnerability comes to the foreground and there is a search for sanctuary and additional support. At first, I named this theme as 'Seeking Sanctuary' but as the analysis sophisticated, an anthropological lens encouraged the renaming of this observation to 'Witness to Transition'. This search was present in the story either when confirming the onset of labour, or in the decision to access the institution for support. These two timepoints were framed within a context of the unknown as labour was unpredictable. They are characterised by the body sensation of movement, and of movement in time, providing an embodied expression of meaning. For example, Maryline had experienced irregular contractions for a couple of days, unsure if it was the start of labour, but decided to seek support from the hospital when she felt them getting stronger:

> "When we arrived, we were warned this could very well be a false start and we could be sent home, which I was prepared for."

In contrast, Lissa was unsure if she would fit the criteria for admission into the institution, leaving her request for sanctuary until as late as she could manage. Thus her entry would signify a legitimate transition to the liminal phase of labour:

> "My two birth stories are fairly similar. Contractions started in the very early hours (DS 12 days early, DD 5 days early), waited at home until they were about 5 mins apart (thankfully we live very close to hospital). Was convinced both times they'd send me home but each time was 8-9 cm!"

In Rebecca's story, she goes for a walk with her husband then sends him to buy snacks while she sits in the corridor outside the labour ward to wait for him. As the lift door closes Rebecca describes having a 'huge contraction', and kneeling on the floor with her head on the seat,

> "I was hungry and was craving something sweet and knowing it might be my last chance to get something to eat for a bit I suggested we walk to the hospital restaurant. We got as far as the lift when I felt like I couldn't walk any further so sent hubby off (after must protesting from him) to get me some food while I waited on a bench. As he disappeared in the lift I had a huge contraction and was kneeling on the floor with my head resting on the seat trying not to push and trying to work out how I was going to get back to the maternity ward on my own".

Her storytelling expertly projects her anxiety - of being out with the sanctuary of the maternity ward - onto the occupational therapist who happens to come past and helps Rebecca back to the ward:

> "when an occupational therapist came past with a wheel chair. She saw that I needed help and managed to lift me into the wheel chair she then ran down the corridor of the hospital pushing me in the chair while I tried desperately not to push.
>
> The poor girl was panicked she literally hammered on the door the maternity ward until one of the midwives came and let us in. She wizzed down to the birthing room followed by my midwife who grabbed a colleague in the panic and literally dropped me onto a bean bag." Rebecca

These examples originate from an interpreted experience of the lived body, and gain meaning through environmental and social feedback. For example, Lissa's labour progression is confirmed. Maryline's story continues to confirm she was also in established labour on arrival at the hospital. Rebecca makes it to the birthing pool supported by the midwives and all progress to give birth. The use of the body in the story legitimises the storyteller to seek sanctuary as a symbol of witness to her transition at a key moment of vulnerability and thus independently supports the woman's decision making or autonomous identity.

A proportion of the stories analysed described first accessing the mother/in-law or partner to share their symptoms and receive confirmation of the onset of labour, as opposed to the institution.

> "…didn't occur to me it could be labour until his Mum said." Amber

> “my labours where all different! with the first baby I had to get induced so never had contractions on my own, so when it came time for baby number 2 to make an appearance I convinced myself I just had bad wind and it wasn't labour! I sent my mother a text to tell her how bad it was when I got a frantic call back saying 'you're in labour',!’” Claire

> “I remember waking up in my at 3.06am with small cramping pains in my stomach, not thinking much of it I decided to get up and just have a walk around. After 20 minutes passing I woke my partner and he told me to phone the hospital to see what they said, which I did.” Kirsty

This search for confirmation could be interpreted as necessary where there is a loss of cultural birth knowledge. Alternatively, accessing involvement of another at the vulnerable time points of labour onset and entry to the institution could be the act of nominating a witness by the storyteller. This nomination of a witness could act to legitimate the pending rite of separation from the woman’s current social role while supporting her social entry into the liminal state of labour and birth. Within Cindy’s story, this role appears to have been taken by the 999 operator in lieu of her physical entry to the institution for birth support. Cindy shares her story of seeking sanctuary from the emergency services (999) as no midwife appeared to be able to make it to her house to support the birth. The 999 operator was on speakerphone while,

> “My husband delivered our daughter…”

This link to an ‘expert’ appears enough for Cindy and her husband in their moment of vulnerability which would be the unwitnessed completion of her rite of passage. Despite her emotional description of the event as

> “surreal, terrifying and exhilarating all at the same time”

She dissociates from her bodily experience when retelling the tale, as her husband delivers their daughter, as opposed to her self remaining within the embodied storyline and birthing their baby. This could be a coping mechanism as she had not achieved the level of sanctuary that would allow her to be fully present within her body. Equally this could reflect the extension of safety from the words of the 999 operator to the hands of her husband, merging his position from husband/Father temporarily to role of accoucher and all the associations of trust, control, and power that role is given in society.

4.3 Dialogic Analysis

Dialogic analysis interrogates how talk among speakers is interactively (dialogically) produced and performed as narrative (Reissman 2008). As stories revise the sense of self and situate people within groups, storytelling responds to others (actual or imagined) while anticipating future responses (Frank 2005). However, dialogic analysis is not just about exploring the co-construction of a story through turn taking as emphasised by Reissman (2008). Instead, it seeks to focus on analysis of the multiple voices speaking through the storyteller that could represent relatives, friends, other birthing women, or health professionals, who are heard through codes of language in borrowed words or phrases. Every story is built from the use of multiple intersecting speech communities, allowing the researcher to identify hidden discourses that tellers take for granted, locate contesting voices in individual narratives and add new voices of interpretation.

Dialogue begins in bodies before it is expressed in symbols and returns to the body following their expression (Wacquant 2004, Morris 2010). Wacquant (2004) and Frank (2005) describe the need for the analyst to get close enough to the dialogue to 'grab it with their body'. Embodied experience of fieldwork supports an awareness of what compels other lives. Frank (2010) illustrates this using the example of being a medical patient analysing stories of medical patients. He refers to understanding the embodied experience of a lack of real choice about being in a hospital; the absolute dependence on others as one's body does not follow the usual known rules of function, and how this experience conditions other actions and attitudes; also having to deal with hospital routines and rituals; appreciating the affronts to dignity being a patient allows while your body is exhausted and in pain, increasing fears and anxieties. I feel my personal experiences of birth have impacted the way I hear women's birth stories. I hear and viscerally feel a range of emotions; frustration, disappointment, resignation, determination and strength alongside a search for connection with the pre-birth self in the experience that I never heard before I had my children, despite being qualified as a midwife. Some situations spark memories of my own experience, or stimulate an emotional response. My embodied re-engagement with my data post birth made more vivid the vulnerability of birthing women and the importance of the body as a site of resistance or positioning of failure.

I have taken three exemplars from the data set of this project to interrogate the dialogic spaces within the stories to complement the results from the structural and thematic analyses. Within these three proceeding analyses, normative assumptions for birth are shared, the language and voice of the health profession is appropriated for specific purpose and the body has emerged as a site of resistance. Interrogating the dialogic space within the stories of my data set has enabled concentration upon the multivocality within the story. The

multivocality of the stories show how wider social concepts weave their way into individual identity performance, while illustrating how identities are situated and accomplished with the audience in mind and as an active presence. Dialogic narrative analysis selects stories on the basis of wisdom gained through analytical experience (Flyvbjerg 2001). Consequently, following the structural and thematic analytical processes, I have chosen three stories through the iterative process of hearing the data set speak to the original research question. The first story is from Alison who shared a positive birth story about birthing in hospital. Its analysis reveals normative assumptions of birthing women's expectations by others of different birth experiences. The second story is by Sophie. She reinforces the hospital birth storyline but with evidence of covert resistance to the rituals and practices imposed as a condition of her admittance for institutional support. The third story by Emma speaks directly to the research question of this project as she starkly shares her vulnerability and the impact of unmet expectations on her birth experience.

4.3.1 Alison – An industrial metaphor of birth

Alison's story was different to the majority of the data set. It was short, in the past tense, selective in the events that were shared, and felt very calm to read as she focused on the positive aspects of her relationship with her midwife. Her story revolved around having a beautiful birth experience, feeling calm, not being afraid, with everything under control.

> "although i ended up with a section i had a beautiful birth experence, the midwife in queen mums was amazing she was kind, thoughtful, caring and made me so at ease when some problems occoured she was calm and reasured me and explained everything.
>
> I had pain relief and after i had evie i got up the next morning and walked around no point lying down it does not help!! i just loved every min of it and even though i needed a section (evies heartbeat kept diping) the care they gave me to make sure all was ok was amazing. i never felt fear as they had everything under control. my mid wife was called paula"

However, the whole purpose of dialogic analysis is that it does not take the text at face value but interrogates the context and the social circumstances of production and interpretation. Taking a step back, this calm, positive story by its very felt sense intimates an expectation, or shared assumption with the forum readers, of panic during labour, loss of control and a context of fear among birthing mothers. Alison's opening sentence implies an expectation of her audience that c/section is not going to be a beautiful birth experience:

> "Although I had a C section I had a beautiful birth experience"

By default, her story becomes a counter narrative to the frequently shared negative experiences of technological birthing while emphasising the 'kind, thoughtful, caring' midwife who made her 'feel at ease'. She is separating the midwife from the out-group of other, sharing her name for the benefit of others and showcasing her role, perhaps as the buffer to the implied potential for a negative experience when there is a medical need for a c/section. Alternatively, this could be an example of Alison protecting herself by inviting the midwife into a relationship of exchange. Alison complies with her directives, forgoing autonomy, in exchange for the care of the midwife and relational fulfilment (Butler 2005).

The institution is very much in control in Alison's birth story but this is accepted by her:

> "she…reassured me and explained everything...I never felt any fear…they had everything under control"

She explains the need for a c/section was because the baby's heart rate kept dipping. There is no description of events leading to this sequela, positioning herself as a passive actor in the institutional orchestration of her daughter's birth. This approach of handing control to the institution clearly worked for her as she never felt any fear, accepting the ability of science to bring her safely to parturition. Slovic et al (2005) describe this as 'affect heuristic', because if the feelings towards birth intervention are favourable, their risks are more likely to be judged as low and the benefits as high. This is a strong antenatal message from the NHS maternity services that has clearly been internalised and accepted by Alison. Her storytelling dissociates her from the active physical experience of birth. However, she negotiates her identity position with the audience as strong, enduring pain and rejecting a dependence narrative:

> "I got up the next morning and walked around. No point lying down, it does not help!"

As agency is a relationship, rather than something you have or do not have, Alison is fulfilling her side of the provider – patient relationship contract as she rejects the patient position of dependence that she entered by the nature of having a caesarean section (Barad 2007). In this performance of regaining control and pursuing the institutional values of independence and resilience, she is complicit with the institution's industrial metaphor. By returning to the normal state of things, or 'bouncing back' once the business of birth is complete, she situates herself as a 'good citizen' (Bracke 2016, Martin et al 2014). Furthermore, she perpetuates the passive stance of neo-liberal resilience where the individual assumes responsibility for structural shortcomings outwith their immediate control (Traynor 2018). This reiterates birth as an inconvenience in the everyday order of activities

rather than a life changing and life defining experience. Alison's support of this narrative suggests colonization by the institutional discourse to imply there is no alternative approach, perpetuating the continued subjectivism of women in this model of birth (Bracke 2016).

4.3.2 Sophie – Resistance to the institutional rite of separation

Sophie opens her story by joking around at her own ignorance, portraying herself as clueless but dutifully following the rules she has learned through pregnancy as she goes to the assessment unit when her waters break. She underlines her lack of awareness and consequently emphasises the knowledge and support of her husband as he brings the bags to the assessment unit and calls a midwife in response to her feeling a need to 'poo':

> "It all happened very quickly, and I was a bit unaware of what was going on!
>
> My waters broke at midday, but I wasn't having any contractions, so myself and my husband went to the assessment unit. Luckily my husband thought to take all my bags as I didn't think we would need them!
>
> After a few hours in the waiting room, I was examined only to be told nothing was happening, but that as I was having some bleeding I may need to be kept in (actually I would have been transferred to a hospital 20 miles away as there were no beds.)
>
> Back to the waiting room I went, I started to get period like pains, and this being my first baby I just though they must be Braxton-Hicks, as they've told me nothing was happening!
>
> I had hour of to-ing and fro-ing from the toilet, telling my husband it was comfier on the toilet because "I needed to poo". When my husband heard this he ran and grabbed a midwife, and garbled something about me needing help! They got me out of the toilet and examined me and I was 10cm and it was time to push!"

This supports the maternity literature that emphasises the value of a birth partner and fulfils the unspoken expectation of the online community of my project that this would be the husband or partner. She portrays her husband as competent and present to a dominantly female forum with a variety of stated relationship experiences. Her subjection to the leadership of her husband is a position I was surprised to see within this corner of the internet that I felt women had claimed as their own. In this surprise is my assumption of the type of message women visiting this forum are trying to share and reveals the true value of dialogic analysis. In Sophie's story the hidden social structures of power and inequality are perhaps more obvious than I realised on initial reading.

The felt sense of her story conveys a performance of labour as a mild interruption in her daily routine, almost blasé in nature, in contrast to a significant proportion of the data set that carried heavy emotion in their descriptions of the experience. This is an example of the constraint in resources available to women to tell their birth story as Sophie's 'interruption' experience reinforces the industrial narrative of birth illustrated by Alison. Circulation of particular storylines creates group categorization and belonging (Frank 2010).

However, Sophie's storytelling style aims to keep the attention of her audience with a dramatic statement of reaching the crisis point of second stage. She goes on to describe the remainder of the labour:

> "They got me out of the toilet and examined me. I was 10cm and it was time to push!
>
> They magically found a room from somewhere and I waddled through wrapped in a sheet with my socks still on (I remember thinking this was awful!) As I was being put on the bed a midwife from pre-assessment came in with some paracetomal for me.... bit too late for that!
>
> My baby boy was born swiftly after all this, and all I could think during the last few minutes of labour was that our car park ticket had run out and we would get a massive fine!
>
> When he arrived, he was placed on me, and my first words were "ooh a baby!"

Sophie takes an opportunity to emphasise how she is the centre of events as a birthing room is 'magically' found and she waddles through with her socks still on. This stanza could be read as a disguised snub to the institution that declared her not in labour and asked her to wait until they arranged a bed in a hospital 20 miles away to monitor her bleeding. She progresses swiftly through labour despite their assessment. However, overt resistance is not socially acceptable and she retracts her potential barb by taking a humiliating stance to her appearance.

> "I waddled through wrapped in a sheet with my socks still on (I remember thinking this was awful!) As I was being put on the bed I remember a midwife coming in from pre-assessment with some paracetamol for me – bit too late for that!"

Firstly, Sophie describes herself as 'waddling' through. This style is in contrast to the socially constructed smooth gait of female elegance, positioning herself as ungainly. This image is compounded by her state of undress in a public space, appealing to concepts of propriety while revealing a vulnerability hidden by her jest. She focuses on the awfulness of wearing socks within this scene which could link esoterically to notions of hygiene as socks are

coupled with shoes. Socks that have been in shoes are traditionally removed before entering the clean linen of a bed. They may also create a link to her non-patient self that she has tried to leave in the assessment room as she transitions into the birthing space and the rituals and preparations connected to it. Alternatively, violating the sanctity of the institutional birthing space with the socks of her non-patient self could reflect a sub conscious resistance to the disempowering institutional rite of separation of Sophie from her pre-birth identity into the role of patient.

There is no mention of the leaking body fluids that would be accompanying her progress to full cervical dilation, instead maintaining an undisturbed external appearance for her audience. This focus on appearance rejects public consideration of the body beneath the surface. Sophie clearly consents to the institutional culture of the birth room, while portraying herself as fully accepting of the passivity of the sick role, as she is 'put on the bed'. This statement also implies that she would not expect anything different. However, she counters this glimpse of vulnerability and institutional compliance with her comment about the midwife bringing pain relief that arrived too late to have any impact. This emphasises the speed of her labour and contributes to a performance of strength in contrast to the institutional feedback that resulted in her waiting for hours in assessment.

She continues to disengage with 'doing the body' in labour and birth and performs a distracted, inconvenience narrative:

> *"My baby boy was born swiftly after all this, and all I could think during the last few minutes of labour was that our car park ticket had run out and we would get a massive fine"*

Her use of 'I' throughout labour and her emphasis on sole ownership of her baby in contrast to joint ownership of the car park ticket following birth acts to position her and her baby as the main actors in this birthing experience. She and her husband came in as a team ('our' car park ticket) but she becomes centre stage despite framing her husband as competent and guiding in the beginning of the story. She withholds the emotions of parturition until she shares her affective vulnerability in the statement at the end of her narrative, framed in an impromptu response to the receipt of her baby;

> "When he arrived, he was placed on me, and my first words were 'ooh a baby!'"

This use of direct speech to the audience is a way to communicate an important message that would be difficult to say any other way. Despite her 'inconvenience' narrative, she narrates a realisation of the significance of the event, changing the felt sense of the story to one of overwhelmed realisation.

4.3.3 Emma – An enduring memory of emotional isolation

Emma opens her story with a tone of regret as her daughter is overdue.

> "My daughter was exactly a week late, but it felt longer as her original due date was a week earlier. I was ENORMOUS and when I thought my tum couldn't stretch anymore it did so I was more than relieved when I went into labour."

This tone of regret characterises the story of her first birth as it doesn't meet her expectations on a number of counts. She continues this heavy tone as she goes on to describe herself as enormous. The fact that she writes it in capitals adds importance to this word in the sentence. Enormity is not usually regarded as a positive female attribute in the UK culture and carries an association of discomfort and restricted movement. The physical ability of her stomach to continue to grow positions her body as productive, but her discomfort is confirmed by her relief at the onset of labour which heralds the return of a familiar body and its capacity.

She woke her husband at the onset of contractions. This is a socially critical moment as Emma begins the transition to the new identity of mother through the start of her labour. This stage is characterised by support and witness, with Emma's story being no exception. Despite an undertone of expectation from Emma that her husband would not accept his position as witness and social support, he goes back to sleep, Emma still attempted to engage with him at this important time. She acknowledges how she felt,

> "Contractions woke me up at 1am, and I woke my (ex)husband up to let him know. He informed me that he needed to go back to sleep, and did so for the rest of the night. Yep, there's a reason he's the ex! A lone first labour is a daunting thing.
>
> I remember watching a Billy Connolly video whilst bouncing on my birthing ball to keep myself busy. By around 8.30 the pain had got too much so I woke Rip Van Winkle and called a cab for the hospital. I was elated to know that my baby would be here soon. If only I'd known she would not be born until 9.23 the next morning!"

I also felt her sense of being alone in reading her words, despite her encouraging attempt at humour 'there's a reason he's the ex'. This feeling was not just about the sleeping husband, but the loneliness that characterised the first half of Emma's story was not filled by a mother or a friend. The impact of her lack of support by someone known to her is emphasised as her other birth expectations are dashed;

> "All the big plans I had for just gas and air and a water birth, I was disappointed to find I didn't enjoy sitting in tepid water, and the gas and air just didn't work for me"

The natural process of birth has been described as an emotional way of knowing (Ryan et al 2011), with the birth partner acting as a buffer to prevent fusion with the institutional birthing model (Davis-Floyd 2003). However, if that relational support is missing, as in the story of Emma, there is a risk of dissatisfaction with the birth experience (Forssen 2012). Without protection of the intimate space of birth, it would be extremely challenging for any woman to block out the white noise of the institution and work with her body in labour to remain in control of the birthing of her baby (Anderson 2000, Kirkham 2000, Akrich & Pasveer 2004, Leap & Anderson 2004, Hunter 2012).

Emma tries to claw back status from the disappointment in herself and her response to her labour as she endures the pain, appealing to a narrative of physical strength. However, she eventually uses her loneliness to justify capitulation to the rituals and measures of the institutional birth model and her relief is palpable. Her story tells the reader that at least she can experience physical comfort in the absence of emotional comfort;

> "I gritted my teeth until midnight and then begged for an epidural. Oh my what a friend indeed. After the loneliness and pain of the first part of my labour, this was bliss. I was relaxed and chatty for hours."

Her physical comfort removes her distress and allows her to dissociate from the labour and cope with the emotional deprivation. However, the impact of the emotional stress on the progress of Emma's labour is still apparent as her expectations are disrupted again (Gaskin 2003, Buckley 2015). She is told that 'unfortunately' she and the baby were in trouble and she was stockinged up for a C-section. She reports this development in a matter of fact, passive tone as if she has withdrawn from emotional investment in the labour. This is continued through to the end of her story about this first birth as she uses the objectifying language of the institution to describe the conclusion. Rather than putting herself into the experience of birth, she remains disengaged describing how 'I had a ventouse delivery'.

> "Unfortunately I was then told that me and the baby were in trouble and stockinged up for an emergency C section. Luckily it didn't come to that and instead I had ventouse delivery. My lovely baby girl was indeed worth the wait.
>
> It took me another 7 years (and second time lucky husband!) to go through it again. I was convinced that the birth would be quicker and easier second time around. It was certainly less stressful being with my supportive hubby, the early stages were very enjoyable. Well, it was shorter. 31 hours instead of 32! Epidural and ventouse, again.
>
> So I am now the proud mum of a 12 year old girl and nearly 5 year old boy. And that's me done!"

The second half of her story opens with the description of a seven-year delay and a second husband to have another child. She skips through the second birth in a few sentences in contrast to the detailed telling of her emotionally isolating experience of the first birth which is now 12 years ago. This suggests the distress associated with her first birth experience remains palpable and unresolved, potentially impacting the physiological similarity of her second enacted birth (Gaskin 2002, Forssen 2012).

From these three exemplars, the incorporation of the birth experience into the post birth identity can be extrapolated from how the storytellers position themselves in the telling of their story. Alison's calm, controlled telling style suggests satisfaction and positivity surrounding her birthing identity as her vulnerability was handled with support and guidance by those she trusted as experts. Sophie's narrative of labour and birth as a surprise, facilitated by the guiding presence of her husband is suggestive of trust in her partner to keep her safe. She expresses her strength during birth almost as her side of the agreement with a hint at ongoing surprise in the reality of what having a baby means. Emma's emotional vulnerability and unmet needs dominate her birthing experiences. Despite a more positive emotional experience during the birth of her second child, Emma's detailed and emotional recollection of the first birth suggests lasting emotional hurt or damage.

Chapter 5 Findings

The foundation of this project lies in my belief that the transient experience of unique vulnerability during birth exposes a woman's identity to messages about her body, her competence and her social positioning. The work done by the storying of birth draws on the reflective resource of memory alongside the woman's understanding and interpretation of her experience. This acts to inform the processual revision of her minded body identity in engagement with the social world. Through the interrogation of 20 birth stories from an online mother's forum, I set out to address the following question:

How do birth stories convey vulnerability in childbirth and how is this experience incorporated into the post birth identity?

Using the analytical approach of narrative analysis as described by Reissman (2008), I exposed my data set to structural, thematic and dialogic analyses to explore the concepts embedded within the objectives of my question. These are vulnerability in birth, childbirth as an embodied experience and the identity work of the birth story. I have presented the project analysis in detail under each methodological title, and will repeat the structure for this discussion chapter, concluding with a unifying discussion that pulls together findings from all three analytical approaches.

5.1. Structural Analysis

Within the stories analysed for this project, I found the abstract of the story to orient the reader to the birth belief model of the storyteller. This position of the storyteller within a birthing discourse helps anticipate the journey of the woman through her story in the achievement or disruption of her birth expectation. Those storytellers who positioned themselves within the 'natural' birthing discourse, presented the messages of their story as control, resistance or advocacy. While the meaning of 'natural' childbirth appears fluid (Downe et al 2001), intersecting with midwifery models of care yet absorbing elements of biomedical practice, the assumption of shared understanding of its core characteristics between the storyteller and the audience is apparent in these story abstracts. This suggests that these expectations are well established within the birthing community and that the identity of the woman in the act of doing birth, alongside the evolving norm of natural childbirth, is continually redefined and reinforced by the repetitive sharing of these birth narratives. This finding reinforces the perspective of Chadwick (2014), that 'natural' childbirth is another master narrative governing childbirth within the UK. Thus, one's storied identity of

natural birth perpetuates the experience of birth vulnerability in the prescription of conditions necessary to fulfil the 'natural birth' ideology and maintain the illusion of a coherent self (Turner 2002).

Within the abstracts of the stories, the storytellers performed a narrative of control within the natural birth model as an expected behaviour as if this characteristic is an accepted component of 'natural' or non-medicalised birth (Butler 1999). Control is aligned with the objective way of knowing in medicine, the antithesis to the unpredictable body residing in nature. The emphasis on control in a natural birth may be evidence of a resistance narrative against technocratic interference by using the language of the dominant biomedical model of birth (Kramarae 2005). This will allow the woman to maintain ownership of decisions about her body in labour and legitimise her experience. Contrary to this perspective is the emphasis on self-control of behaviour and emotions inherent in the governing practices that accompany living the life of freedom and choice engendered in the Western world (Rose 1999). Control mitigates against dependence, closing the boundaries opened by vulnerability by emphasising characteristics that signify strength and power, falling prey to the subliminal governance of an individualistic society.

Those stories that described a medicalised birth used a longer abstract to justify alignment with the biomedical model. Alignment appeared reluctant but the strength of the narrative of safety and authority of the medical diagnosis in birth served to reinforce the low status of the woman versus the child (Parry 2006). The authority is then unquestioned and compliance assumed among the audience. A study by Kornelson (2005) found women birthing under a medical model to be more likely than the home birthing group to see technological intervention in a positive light. This finding fits with Seel's (1986) assertion that during the liminal phase of birth, women are vulnerable to subliminal messages that can result in cultural entrainment. Tronto (1993) takes a wider sociological view and describes this compliance as a gendered response to authority, revealing an embedded structural vulnerability of this group of women to the institutional power of medicine and the anti-vulnerability discourse of safety. The depth of this compliant learning can be linked to the historical controls of women's behaviour in society and the control of one's body-property to gain legitimation of knowledge as reviewed in chapter 2. The vulnerability of the women telling these stories about birth is also seen in their emphasis on the need for determination to retain the prized characteristics of control and relational connectivity within the experience. When these expectations were not met, their loss became a source of anger. This signifies a defence reaction against vulnerability as the self has been exposed by frustration of its desire for agency and connectivity. As the self is constituted by its relation

with others, denial of that relationality will undo it (Butler 2005), the consequences of which are seen in the women's enduring emotional response.

The orientation clause acted as a defence of the storyteller's response to their birth within a context of assumed shared understanding and judgement by the audience. The principal birth characteristics defended were an inability to act on bodily messages and of not meeting birth expectations in the enactment of the body in labour. This bodily vulnerability is personal and institutional as women's expectations of enactment of the body originate from a social discourse by which the storytellers feel an act of judgement (Oliviero 2016). This self-scrutiny is a component of Rose's (1999) theory, 'governing of the soul' where we evaluate ourselves according to criteria provided by others and experience anxiety or unease by normative judgement of what we could become. In the case of these storytellers, that fear is identification with the medical model in birth. The storytellers share the disruption they have experienced in the communication between birthing context and the material body, turning towards alternative support mechanisms and models of enacting the body in labour. This finding shows how the natural birthing discourse, that emphasises listening to the messages of the body, sits as a counter discourse to the biomedical model. Butler (2014) describes this as the performance of resistance by 'differently positioned' bodies. However, the defence illustrated in the orientation clauses of these stories highlights its paradoxical position (Chadwick 2014). Within these examples, the projection of blame and defence of the storyteller's behavioural response to birth indicates a cover for internal damage to the self. This could be a result of shame or disappointment in the unfolding of events against the expectation of behaviour, proclaimed as one's own expectation but in reality, a normalized internalisation of discourse (Butler 2005). However, this ownership of expectation that was always going to be challenging to fulfil in the institutional context offered for birth, results in an ownership of the failure, affecting the developing perception of the self and resulting birth identity. Seeking admiration from the audience (for example Claire, who arrives at hospital in advanced labour though blissfully unaware) or projecting blame on to another in the cases of Suzanne and Tammy are classic psychological defence mechanisms to maintain coherence within the life story and the perception of self held by the woman (Brown 2010). Drichel (2013) describes these defences as retaliatory violence against another who may, or may not, exploit the vulnerability and expose the person to harm. This action serves to protect the identity of the individual against the threat offered by their storied experience of birth.

Martin et al (2014) describe agency interests as the second reason for ascribing vulnerability upon a person. Agency refers to values, principles, beliefs and the ability to pursue them. Within the main body of the stories, the vulnerability of the birthing woman is foregrounded by her resistance through a 'protest event'. This protest described an embodied action

restoring agency to the birthing woman and typically appeared after a storied period of uncertainty or dependence. The storyteller uses her body in communication with the environment to exact a protest against the master narrative of the institution and its prescribed controlling rituals of birthing bodies (Krook 2007). This demonstration of meta-control in a birth act challenges the inhibited intentionality inscribed upon female bodies by society (Young 2005), and the institutional expectation of behaviour (Parson 1951) opening new spaces for the transformation of culture (Schilling 2012). Butler et al (2016) advocates for such a transformation by disconnecting vulnerability from injurability, instead mobilising the concept as a form of activism by differently situated bodies performing resistance. Within the stories of this project, this resistance narrative impacts the power relations at work through the woman's body, intersecting with her becoming identity as it impresses upon the self, bringing feelings of embodied awareness, strength and achievement (Bamberg 2004). The body becomes a site of discursive control and of enacted resistance as only the body can be truly interpreted by the storyteller, producing particular modalities of being in birth that embrace rather than try to discipline the uncertainty inherent in vulnerability (Ehlers 2014). In this way, the body-based descriptions of the storytellers create a space that invites the audience into a kinship of protest through activation of their own bodily sense of performing the action (Ellingson 2017).

Reflective construction of meaning that turns an event into an experience is evident from the inclusion of evaluation clauses throughout the stories. These serve to connect the emotional and physical experience of the birth to the needs and desires of the storyteller, essentially aligning what happened with the expectations held prenatally (Labov & Waletzky 1967). Within this reflective construction of meaning, handing control to the birth attendants in contrast to striving for a natural birth was legitimised in the stories by a fear of birth. This can be interpreted as an internalisation of the birthing discourse of risk and safety promulgated by the biomedical model of birth. This message of safety can be attributed as the justification for the violent acts of 'defence' wrought by many medical interventions (from vaginal examination, routine cannulation, restriction of mobility and nutrition in labour, clipping a monitoring electrode to the scalp of the fetus, instrumental birth practices etc) to preserve against the unpredictability and uncontrolled corporeality of birth, when operating within a context that views vulnerability as a threatening exposure to harm. Drichel (2013) describes such a situation as a 'short circuit of violence' (p6).

Rather than being subjected by the power of the institution, this could be interpreted as a woman engaging in protection of the self by prioritising the achievement of a supportive relation with the birth attendants over the need to physically orchestrate events of the birth (Lupton 1997). By positioning herself as 'helpless' or vulnerable, she invites her caregivers

into a relationship of exchange in order to be helped, forgoing self-sufficiency and autonomy to orient towards relationality (Butler 2005). Butler's ontology of vulnerability relies upon the interdependent corporeality of people. Consequently, the 'injury' experienced by one's intrinsic vulnerability is losing that relatedness or having the openness to relationality exploited. This can lead to frustration, externalised as aggression, turning against the satisfaction of relatedness and closing boundaries on our vulnerability (Drichel 2013).

The liminal experience of labour where the storyteller moves between bodily states is a highly vulnerable and emotional experience as she is subjected to a barrage of messages and learning about herself from her own interpretation of events and from the responses of those around her (Davis Floyd 2003). Evidence from the stories of this project suggest a lack of time to process this information, if the storyteller's transition to birth is too swift, can lead to the storyteller feeling overwhelmed. Felicity brings these two needs together, of supportive relation and appropriate transition time. She reveals the true trauma in her stark experience to be the deficit in relational connectivity as there is no ethical recognition of her need (Butler 2012). Her agency and welfare are harmed as she opens herself asking for help that is denied (Martin et al 2014). She describes support as more than just the physical presence of others, expecting a quality of interaction in relation that was missing. Proponents of Levinas would argue Felicity's position of vulnerability to confer a responsibility upon the health care workers around her to respond, calling for vigilance against aggression that her fragility may provoke. Telling her she is not a priority case in response to her request for pain inflicts damage upon her identity. While denying her call for help, her suffering is not acknowledged and she is positioned as not worthy of admission for sanctuary. Felicity's storied lack of support is compounded by the speed of transition through the liminal phase to leave Felicity feeling physically and emotionally traumatised. It is well documented within the trauma care literature of the need of the traumatised to have their suffering acknowledged, enabling them to reconnect with those in the 'normal' world (Mollica 2008). Felicity illustrates the violence of vulnerability that Drichel (2013) describes as leading to a renunciation of the need for relationality and retreat into self-sufficiency. This could explain findings that interpretation of the birth experience has the potential to impact upon the woman's future engagement with health services (Pires et al 2002, Bowser & Hill 2010), her self-esteem (Kennedy et al 2003, Leap & Edwards 2006, Forssen 2012), bonding with her infant and adjustment to parenthood (Fahy & Parrett 2006, Nicholls & Ayers 2007, Stephens 2008).

The resolution clause within the stories of my project was overwhelmingly action oriented with the achievement and contribution of the woman to the birth event made clear. Enactment of the body is used to position the storyteller as the central actor in her birth story. Her success is emphasised through the baby's characteristics of weight, health and

beauty. Some stories focused on the performance of an identity of strength through spatial movement metaphors, using the birth context as an opportunity to express characteristics not usually socially celebrated in women (Young 2005). The resolution of the stories emphasising a narrative of strength sits in contrast to the storied realities of vulnerability implicit within the data set. It may reflect a protective response, recovering personal capital following the temporary experience of weakness and dependency implied by the negative interpretation of the concept of vulnerability. Furthermore, is the emphasis on success and strength in the resolution of the stories that served to position the storyteller as authentic in her experience, legitimising her contribution to the achievement of birth in a disembodied structure that 'delivers patients' of their babies. Such bargaining by the storyteller could be her contribution towards a missing social rite of incorporation.

The coda clause revealed the affective context of the story from the current perspective of the storyteller. Affect is situated outside of the body and is concerned with how emotion occurs in everyday life with the body as its key location (Thrift 2007). It can result in vivid and somatic stories, as seen in the stories of my project as it acts to blur the mind-body division (Misztal 2003). The coda was either positive or negative. In those that were positive, they reflected a sense of coherence achieved through the storying of the birth, looking forward to the next birth, and describing fulfilment from the experience. Mead (Morris 2015) describes how working on the memory of the social interaction and the individual's personal response to that can alter the action that is storied following a process of the 'inner conversation'. This conversation needs an audience, such as the listener of the story, to be actualised. Mead credits this process with restoring coherence to intersecting identities, which would naturally be challenged by inclusion/renewal of the mother identity at the culmination of the birth story. In those that were negative, the current position of the storyteller suggested incoherence, requiring healing. Examples include hints at psychological trauma, emotional overload and disappointment with the experience expressed through a strong desire to birth out of hospital next time. These stories were highly detailed, showing an emotional reliving of the birth from the inside (Misztal 2003).

The body featured prominently in every section of the structural analysis. Bodily capacities and limitations negotiated spaces between the dominant discourse to construct layers of meaning for the storyteller within her birth experience. Through enactment of the body in labour, the restricted intentionality of the female body was challenged and the moral position of the self to counter the restrictive medical discourse through resistance was realised. Resistance through enactment of 'doing the body' in birth emphasised the relations of material and social dependency experienced by the storytellers. However, the gathering of

evidence of that exposure through public storytelling demands turning the spotlight of exposure onto the failing infrastructural conditions of birth in this country (Butler 2016).

5.2 Thematic Analysis

After submitting my data set to structural analysis, I returned to the stories as complete narratives to apply a thematic analysis approach. I extracted four themes named as: (1) White Noise (2) Doing the body (3) Bargaining Authenticity and (4) Witness to Transition. Situating these findings within the discursive context of birth in the UK today revealed interdependence between the themes and underpinning theories that could explain them. The routine measurement practices required for medico-legal reasons during birth can communicate certain understandings about the birth experience, implying imagined risk and disrupting the normal (Scamell 2011). This is because the systems of ideology and power, namely science and its variables of measurement, risk, and control, are shared and reinforced through the communication practices of labour observation, quantification and restriction. If this is the context against which the content of experience is lived, it is no surprise that the woman's interpretation of her body 'doing labour' is crowded out (Denzin 1992). I saw this disruption within my data set and named it 'white noise'. This appeared to sow doubt and humiliation in the mind of my storytellers while also muting her experience for the attending midwife (Kramarae 2005). This is suggestive of the fact that the white noise can act upon the midwife as well as the birthing woman. Pressure from obstetric policies and the institutional hierarchy governs midwives to conform to the medical system of birth despite their remit of facilitating normal (Keating & Fleming 2009, Hyde & Roche-Reid 2004).

Moving the private act of birth into the public arena by seeking entry to the institution, emphasises the presence and impact of this white noise that is grounded in the discursive norm of autonomy. A number of stories of this project gave voice to the fear of potential humiliation that would result from being turned away from the institution because of not fitting the 'experts' admission criteria of being in active labour. The violence implied by this refusal is the constitution of the woman's private birth experience as not worthy, and discrediting its public validity by suggesting that the woman is unable to interpret her own body in labour. Those storytellers, whose previously successful responses to their body were inferred as inadequate by such institutional interactions, went on to display classic shame behaviour of either withdrawal or blame when they were denied help on their terms (Brown 2010). This withdrawal from others or need for 'shielding boundaries' (Drichel 2013 p7), as a response to threat acts as a problem-solving strategy, and is characteristic of a system of individualism where individuals are expected to solve problems without help from others (Stearns 1994).

In the most extreme case of trying to enact the 'expert' advice, Wendy's withdrawal by keeping silent resulted in an unscheduled birth at home. Although this is an unusual conclusion, the stories of Amber, Wendy and Gemma shared Wendy's characteristics of a shame response where the institutional narrative had impacted the minded component of the woman to muffle that of her body.

The theme of 'doing the body' extracts a resistance narrative from the storytellers. Storying of the woman's emotional interpretation of her body's situational response, opposes the muting impact institutional 'white noise' often had on her body in labour. Emotion has been credited with connecting the worlds of materiality and embodied interpretation (Thrift 2007). It has also been described as a reconstructive act, formulating identity that is articulated through narrative (Guest 2016, Lawler 2014, Misztal 2003). The examples offered in the stories of my project connected feelings with meaning, in the form of a situational response, through the use of emotive language. In support, female online communication has been described as emotional (Herring & Stoerger 2014). This emotive lexicon, verbalising the minded body in labour and its interactional response, is allowing these storytellers to take up linguistic and political space. Butler (2016) describes how media can form infrastructural support to resistance by establishing new spatio-temporal dimensions of the public sphere to facilitate modalities of solidarity. While vulnerability to the white noise of the institution is not overcome by the resistance of the 'protest event' discussed within the structural analysis, it is enacted publicly. This public exposure of vulnerability to an infrastructure that is failing in its duty to birthing women to support them in the birth conditions they expect, shows how bodies are being acted upon and the plurality and performance of resistance at work (Drichel 2013).

The plurality of resistance includes the celebration of women's birthing discourse and reclaiming of the shaming language of emotion and the body. However, in my data set, it is clearly still in the early stages of challenging the muting status quo (Kramarae 2005). Within the narratives of this project, the storytellers either framed their story in a disembodied reporting of events using the technical language of medicine, or switched between an emotive, body-based style to include disembodied reporting of measurements at certain timepoints. These timepoints were: the 'diagnosis of labour'; 'admission to the institution'; 'transition to second stage' and 'parturition'. It is as if the emotive, physical experience of birth required these technological anchors, from the language of the dominant group of medicine, to legitimise the woman's transition between phases in the birth process. This is a clear example of 'muting' in action (Kramarae 2005). It occurs when people are unable to articulate their ideas without changing their language to meet the dominant group's vocabulary. This is because of a disregard of the marginalized voice as there is not a

publicly recognized vocabulary to express their experience. The storytellers of this project were seen to perpetuate the collective understanding of who is in power and who is not, by this incorporation of medical language, augmenting their own invisibility. This dialogic nature of storytelling acts to reaffirm the subjective identity of the birthing woman within this medical discourse (Baumeister & Leary 1995, Morris 2015).

Within the dialogic affirmation of the identity of a birthing woman in this particular online community sits the theme of bargaining authenticity. This was characterised by a performance of suffering, framed for an audience assumed to believe in 'natural' birth as the ultimate goal, by emphasising the importance of endurance. This was illustrated by the counter narrative of Nicole where she denied her achievement of a swift, natural birth without painkillers or intervention to stand in solidarity with the majority of women whom she assumed had not achieved the same. This denial is used as a political platform to demand acknowledgment of the importance of labour endurance in the experience of all birthing mothers. She emphasises her sense of relational connectivity by accentuating the similarities between herself and other mothers, both on the postnatal ward and as potential readers of her story (Butler 2014). She then moves to a depersonalized tone as she takes up her argument against the midwives on the postnatal ward, forgoing emotion to appropriate a factual argument to gain voice among a different audience, extending her focus to a higher level of abstraction as she includes society generally (Hirsch 2016, Kramarae 2005). This process acts to redefine herself from a mother achieving the elusive natural birth implied by the stories of this project as the ideal, to one desperate for an epidural to support her to endure her labour. By making the claim at the end of her story;

> *"I hate that people see pain relief in labour as a weakness! I can guarantee you I didn't get a medal for it n I would absolutely make sure I got the epidural next time (if there is a next time lol) x"*

Her subjective uncertainty from being perceived differently moves from activism and resistance to overwhelm her (Turner 1982). Consequently, she tries to resolve her unease by overcompensating in her conformity to the perceived norms of the mother group and specific way of being in the birthing discourse. This is positioned as an attempt to bargain her entry to it (Rose 1999, Livingstone et al 2011). In contrast, Nicole's story could be read as a rejection of the resilience narrative that frames an individual as coping with stress and 'bouncing back' (Bracke 2016). Within the neoliberal code of western society (Rose 1999), resilience positions an individual as a 'good citizen', carrying an expectation that experience of the shock or adversity will make one stronger (Traynor 2018). Bracke (2016 p67) describes how the imagination is colonized within this discourse to believe that there is no

alternative approach, undermining any capacity to imagine another way or the 'agential modalities' to pursue those imaginations. Nicole rejects this formulation as she embraces vulnerability and resists the resilience narrative. She moves from a storyline that seeks community recognition, framing identity as the asset for collective struggle mitigating the vulnerability induced by structural conditions, to one acknowledging bodily vulnerability to pain and a desire for alternative modalities of experience. Alternative modalities of experiencing and living with birth vulnerability are offered through her rejection of the 'natural birth' desire intimated on the forum as the ideal. Her story sits as a starting point to contest the interlocking systems of structural and discursive violence through the staging of political action in her demand for 'an epidural next time' (bell hooks 1994).

Nicole's emphasis on the importance of labour endurance experienced by all women uncovered a split in the data set in the framing of endurance. The burden of endurance was used as justification for behavioural deviance or as a topic for status work within the story. Those storytellers framing their experience of labour endurance as justification for acceptance of an undesirable act of intervention or 'inappropriate' behaviour within the story, suggests internalisation of discursive constraints to doing the female body and acceptance of the bodily failure narrative. The bodily failure narrative reinforces the view of the female body as faulty, legitimising the move to a medicalised birth and reidentification of the birthing woman as a patient. In my project, I classify labour and birth as the liminal phase in the transition rite to motherhood where the woman is vulnerable, she is in a state of openness (Butler 2014). Within normative conceptions of bodily vulnerability, this openness may result in harm or threat to her minded body experience of labour due to the paternalistic guise of special protection (aka restriction and measurement), aiming to *prevent* manifestations of vulnerability as they define them through their presupposed knowing (Martin et al 2014).

The telling of 'inappropriate behaviour' through the story, revealed an identity struggle in the woman between her representation as a patient and her locus as a birthing woman. The narrative of struggling endurance is presented to the reader as a reason to disconnect the storyteller from her material body in labour as she tries out the storying of her resistance behaviours, that include verbalising, birthing on all fours or in a standing position, or otherwise being unco-operative with the directions of the birth attendant. These 'uncontrolled' behaviours could be stigmatising for the woman as non-conformity with authority connects with memories of the historical controls of women's behaviour by the institution through accusations of mental weakness and removal from society (Goffman 1959, Showalter 1985, Ussher 1991, Martin 2003). These memories are not fully confined to history as the power of medicine in directing regulation of the self remains a significant authority in the regulation of our neoliberal contemporary society (Bracke 2016, Lawler 2014,

Rose 1999). However, I feel the storyteller is actually trying out an new understanding of herself post birth experience upon her audience. She hides behind the material body struggling in its endurance to tentatively present a narrative of resistance. Using the potential offered by vulnerability as a form of activism is a bold and novel politic.

The second thread in the use of endurance, informed the status work of strength in the woman through her endurance of a fast and intense labour. This sub section of the data set carried a definite flavour of competition. Competition suggests rivalry or a contest. Bracke (2016) describes it as a 'Look I overcame' narrative, implying the question of 'So why did you not'. She positions this narrative at the heart of post-feminist rhetoric and as a political opponent to vulnerability that undermines resistance. The damage that has resulted from swift progress through the transition phase of labour, which has been linked to psychological processing of the experience and fragmentation of its learning (Habel et al 1993, Forssen 2012), is now turned into human capital or personal growth within a discourse of resilience. Within the birth stories of this project, the contest seemed to revolve around a popular social image of athleticism as a healthy ideal promoted in the project of the self (Rose 1999). The emphasis on strength as a traditionally masculine trait alongside other characteristics of courage and independence (Butler 1999), may be performed as an attempt at alignment with a dominant discourse in the search for recognition from the institution of their rite of passage to becoming a mother. Thus, these stories of endurance are not just intra group competition to bargain their suffering as authentic admittance to the mother group, but also signify inter group communication with the attending midwives, seeking validation for the authenticity of each individual experience.

Within the theme of witness to transition, the storytellers share their interpreted experience of the lived body with a significant other. Accessing the involvement of another, such as a partner, mother or friend, at the vulnerable time points of labour onset and entry to the institution could be interpreted as nominating a witness to the rite of separation by the storyteller. This nomination of a witness could act to legitimate the pending rite of transition from the woman's current social role through the liminal state of labour and birth to that of mother. The interpretation of social interactions, perceptions and emotions within an experience is linked to the formation of identity through reflexive construction within the self (Dunn 1997, Morris 2015). Mead describes difference to be an inherent feature in social relations, constituting identity by giving structure to the self. Perhaps in the context of expected difference that accompanies the circumstances of birth, the presence of a person with whom the storyteller has already negotiated their identity provides a degree of psychological stability and anchors them socially within the narrative. Furthermore, the transition phase between the old and new is often described as dangerous to the initiate and

to those around them. To mitigate this influence, a sponsor is usually provided to protect candidates (Habel et al 1993). Research has overwhelmingly shown the benefits to women and their labour of continuous care from a known care giver (MacLellan 2011), holding the intimate space of birth even in a clinical setting (Hunter 2012). This does not have to be a birth professional (Campbell et al 2007). Therefore, another aspect of gathering one's significant persons around them in birth could be to initiate their participation and document the birth rite, provide that continuous support in labour through a protective sponsor, who will also advocate for the birthing woman in the natural process of birth (Habel et al 1993, Mansfield 2008, Sioma-Markowska et al 2015).

5.3 Dialogic Analysis

I interrogated three exemplars from the 20 stories of this project to reveal the multiple voices contained within the dialogic spaces of the narrative. The story is the presentation of a drama to an audience suggesting identities are situated and accomplished with an audience in mind. Pre-existing discourse is accessed and amalgamated to construct and justify a sense of 'self' and is revealed in the contextually dependent references employed in the relay of the story. As such, these stories share as much about a society and points of culture as they do about a person (Reissman 2008), carrying hidden voices of politics, history and culture and creating opportunities for multi-layered analysis (Bakhtin 1981). The stories of Alison, Sophie and Emma complemented the structural and thematic findings to expose the systems of power and ideology shared through the communicative medium of the story.

Alison's story reinforces the institutional narrative of birth as an interruption in the normal business of daily life. Sophie reflects this storyline, illustrating the restriction on accessible storylines for birth, shared to enhance group belonging (Frank 2010). As Alison stories her resilience, she rejects a dependency narrative, fulfilling the requirements of a 'good citizen' as she bounces back after her caesarean section (Bracke 2016). However, the positive relational experience Alison has with her midwife during the birth can be read as the priority outcome for Alison. Relational connectivity appears a significant expectation among both the written literature and the stories of this project. Alison exchanges autonomy in her labour through compliance with medical controls to receive this relational support. The importance of the relational over the material body is explained by the philosophists of my methodology as fundamental to a person's sense of existence. Butler (2005) describes how the relationship between 'I' and 'you' brings the 'I' into existence. Mead (Morris 2015) credits the self as arising out of reflexivity on the socialization process, making the individual the reconstructive centre of society as they communicate cultural meanings. As Alison adjusts

her behaviour in response to the attitude of the midwife, in compliance with the resilience model favoured by the institution, she strengthens the message that there is no alternative modality available to ‘do birth’ (Bracke 2016). Such socialization reflects the individualistic approach to resilience of our society, viewing it as an innate characteristic in an individual, community or society to positively adapt to significant adversity (Castleden et al 2011).

It is clear the relational support or social model of birth sits as a normative requirement for birth among the forum participants as Emma uses its absence to justify her move to a medical model. Despite the overwhelming use of the medical model for birth in the stories of this project, and in national birthing statistics, there is still a firm assumption among the storytellers that a natural birth is the ideal that all women must try to achieve. This illustrates a significant system of ideology at work in the co-construction of the birth stories on the website.

Chapter 6 Discussion

My project question opens with the exploratory proposition of how do birth stories convey vulnerability in childbirth. My assumption that childbirth is a uniquely vulnerable experience is clear by the second half of the question as I aim to explore how this experience of vulnerability is incorporated into the post birth identity. In the literature review that situates my project, I have looked at the vulnerability of the physiological birth process to disruption using the language of hormones and scientifically observed processes. I have extended the conceptual perspective to explore the social and emotional vulnerability encapsulated in a discussion of birth as an anthropological rite of passage.

I thought taking a dictionary definition of the word vulnerable might provide an anchor upon which to attach these different interpretations. I did not appreciate at the start of this project the ideology contained within words and that I was, without realising it, starting out from a particular theoretical position that viewed vulnerability as a negative characteristic from which protection is required, framing dependency as a state of pathology. I did not appreciate the protective measures stimulated by this interpretation of vulnerability to be as potentially harmful as the original threat to which the birthing woman was classified as being vulnerable (Butler et al 2016). This position of vulnerability as open to threat or harm, resonated with my personal experience of my first birth where my husband and I transferred to hospital in the 'pushing' stage. We went from the calm environment of our home to a brightly lit, noisy room with 8 professionals busy doing procedures and discussing intervention, with little concern for my comfort, dignity or consent. I felt extremely vulnerable and helpless until the midwife asked everyone to leave and we continued with the business in hand together. I looked for an ally to negotiate this hostile territory and the midwife stepped in to that role. I consciously traded certain conditions relating to birth position, second and third stage management of the birth in exchange for this support and protection from the greater threat of medical intervention that waited outside the door. I gloss over these details in my birth story, recounting the achievement of a normal birth as just that, an achievement. The experience of vulnerability and my management of that experience is not said directly, but my omissions will inform the experienced eye of a reader. Following engagement with the literature through the course of this project, I am now aware that the view of dependence as pathology and engagement in protective behaviours within that relationship is a core concept of Rose's (1999) governmentality in the project of the self, protecting autonomy as the ultimate social goal. This conflicts with a supportive community model of birth that views vulnerability as a positive experience, an opportunity for growth in the woman and her family that supports community with others (Kitzinger 2015).

Such a positive view has been developed by Butler as a negative *capability* that can be used as a political tool of advocacy where differently positioned bodies can enact resistance. I experienced this opportunity for growth personally in my second birth which took place at home. I was emotionally and socially vulnerable as I shared the raw physicality of birth with my family. The effort moved me out of the traditional supine birthing position the midwives were encouraging me into, and pushed out sounds from deep inside that I could not hold in contrast to my usual nature. Sometimes such sounds are described in the literature as primitive but I describe them as unifying and feminine. They connected me with other birthing women across time and space and I felt the power of birth. This power brought our son safely into the world and a positive wave of closeness and achievement in our family that came from our dependency upon each other's strength. We had created our micro community of birth described by Sheila Kitzinger (1974), while I had connected with a wider community of birthing women by sitting quietly in my vulnerability and opening myself to be affected (Gilson 2011). The passive resistance offered by this storyline is an alternative modality of 'doing the body in labour' that accepts the embodied vulnerability inherent in the rite of passage and works with uncertainty to facilitate the flow of birth. Hirsch (2016) describes the openness created by the admission and acceptance of vulnerability to produce strength and foster connection. This source of passive power naturally inspires a political platform to demand change in the institutional control of birth, and opens a space for the transformation of culture (Schilling 2012, Vacchelli 2018).

The movement and sound of my birthing body was reflected in the protest event clauses of my data set and sits as a challenge to the inhibited intentionality imposed upon women's bodies by society (Young 2005). Many of the women of my data set demonstrated their resistance by challenging modalities of 'doing the body' in labour, and in their use of language to articulate this way of being. Descriptions of the use of their body in communication with the environment, positions their acts as a symbol of resistance against the restricting narrative of the institution (Krook 2007). Young (2005) describes such embodiedness as liberating, empowering and agentic, reminding women of being a child and inhabiting a less problematic body. This is evidenced by the women of this project who take control in their 'protest event' and move into positions comfortable for them to give birth. This protest destabilises the biomedical conceptualisation of the birthing body as solely a source of risk and potential dysfunction as the women proceed to birth (Chadwick & Foster 2014). Use of the body juxtaposes the vulnerability of the individual's body against the power of the institutional birth system, drawing attention to the inequality and perceived injustice of the situation (Lunceford 2012). In this way, the body becomes a site of control as the storying of

the resistance act contributes to the discursive construction of her identity (Bamberg 2004, Long 2015).

Through this protest event, women are challenging the helplessness of vulnerability, returning agency to their body and following its direction. The bodily positions adopted by the birthing woman, in contrast to that preferred by the institution, signify strength in the women and ascendancy of nature (the material) over culture (the institution). The storying of this bodily resistance redefines the identity of the woman which is reinforced in the community by its repetitive sharing (Vacchelli 2018). Thus the audience is invited into a kinship of protest through activation of their own bodily sense of performing the actions (Ellingson 2017). Activation of bodily sensations can also be achieved through the shared meanings within the story as storytellers try to describe their feelings within the birthing situation. The absence of a sufficient lexicon for the storytellers that appropriately captures the defining emotional and bodily feelings of her experience necessitates a storying of the experience to share the meaning with the audience. For example, with regards to relational support, Emma describes how 'A lone first labour is a daunting thing'; Felicity recounts how 'I was all alone, apart from the midwife (and all the other ladies in the ward, just outside the toilet)'. The descriptions are inadequate on their own, and my notes in the structural analysis grid differed from my first review of the data compared to my notes after I had personally experienced labour. My postnatal analysis was rich in the feelings these statements provoked. Emma describes a lone first labour, referring to the non-participation of her partner and no attending mother or friend. She would not be physically alone as she birthed in hospital with the midwives and medical support. However, I understand her sense of being alone as not having a witness and advocate from her life world who knows her as Emma and all those identity nuances she carries, supporting and being with her in her transition to motherhood through the physical challenge of labour. This is about having an anchor to prevent temporary reidentification as a patient in the system of birth, someone to facilitate fulfilment of the important characteristics of her identity that are contained within her birth expectations and plan, and for someone to witness the significance of the journey. I am not sure if i am eloquent in explaining my understanding and interpretation of her words as I also turn to story to try to describe that visceral feeling her sentence evoked. The same applies to Felicity's description of feeling alone despite the physical presence of many people. As she shares no emotional connection or communication with them, her sense of loneliness is emphasised by their presence. I believe I can empathise or identify with her feelings but cannot capture it in a word or phrase. Tammy also uses no specific adjectives to describe the positive experience of relational support that she experiences but the affective response

evoked by the feelings transmitted in her sentence captures it clearly, ‘My little boy arrived with 3 midwives, my partner and mum around me’.

The muted group theory of Kramarae (2005) speaks to this experience I have seen and shared in the storying of birth. The linguistic restriction imposed by the deficiencies of the available lexicon result in an attempt to convey meaning through the storying of the feeling or situation. This is a pertinent example of how not all sections of society are served equally by their language since the formulation of language is confined to a privileged group. Consequently, subordinate groups, such as birthing women, are rendered ‘inarticulate’ because the language they must use is developed by the knowledge of the dominant group, which naturally differs from their own (Turner 1992). Lakoff (1973) described how a female must learn two dialects, that of a woman and the neutral language of male dominated society. While her command of each language may be adequate for most purposes, she may never be truly comfortable in her bilingualism. Consequently, she may never be certain that she is using the right one in the right context and with the right person, leading to expression of uncertainty. As codified language has been and continues to be largely constructed principally by men, many of women’s unique experiences in life are not named in English. Thus, a translation process or storied description is required to convey meaning as the available lexicon does not provide a good fit with their life’s experience. Turner (1992) describes how the woman must first cognitively identify the experience for themselves before scanning the male-centred lexicon to locate a word that most closely approximates the experience.

Describing their positive feelings after birth, many of the storytellers of my sample drew on themes of elation and achievement within a specific context of physical exhaustion: ‘the most magical experience of my life’ (Dania); ‘I was tired, hungry, happy and relieved but the strongest feeling was one of empowerment’ (Maryline); ‘It was surreal, terrifying and exhilarating all at the same time’ (Cindy). Anecdotally the feeling has been compared with the exhaustion and sense of achievement and relief associated with winning a marathon. Dania even says, ‘…you wouldn’t run a marathon without training so why not get as ready as you can for this?’. However, this marathon analogy draws on an activity that is pursued alone in a context of competition. This competition is either of the individual’s strength of mind against the strength of their body or of the individual person competing against the endurance of other individuals. It draws on competition, strength, and athleticism narratives. Such an analogy is a classic example of a traditionally male-centric word used to inadequately describe a female experience. Add to this endurance analogy the expectations, emotional and physical feelings linked to the prize that within a birth context are facilitated by a whole-body cascade of hormonal and bodily processes. It is easy to appreciate the need of

the storytellers to verbalise their minded body experience through an emotive lexicon. It appears as the most appropriate and available language resource to stimulate an affective response in the reader. This is felt to be required to support understanding of the meanings contained within the teller's storied experience and allow these storytellers as a community to take up linguistic and political space. However, emotive language is often dismissed as subjective, clouding the objective and thus measurable variables of an event by the dominant cadre. This view demotes emotive language in the hierarchy of knowledge. Throughout this project I have recorded birthing women's approach to birth as relational, contextually and socially oriented in contrast and conflict with the individualising approach of science, without a dedicated lexicon to support its description. The expressions that are mobilised can therefore appear tentative, emotional and adjective laden or require storying to convey meaning, impeding free expression of women's alternative modalities of being in the world (Kramarae 2005).

With this context in mind, I found all of the storytellers in my project to appropriate factual terminology at key stages of their labour journey, acting as a technological anchor to legitimise experience with the authority that medical classification carries. For example, some women would express how they 'knew what they needed to do' while others used the medical terminology to signpost their progress and state 'I was fully dilated and ready to push'. This is an example of muting in practice as the language of intuition used in the first example is replaced by that of the dominant group of medicine in the second example. To counter act the muting process West & Turner (2010) describe how it is essential to name the silencing factors and reclaim women's discourse. The storytellers of this project are reclaiming the language of the unpredictable body and its emotions that has historically been used to deride and subjugate women in society by storying their experiences (Dennison 1988, Long 2015, Showalter 1985, Ussher 1991).

However, to progress from a storying format of meaning exchange, West & Turner (2010) recommend the creation of new inclusive words which would expand the linguistic choice available to women to describe their experiences and increase understanding beyond the exclusivity of the birthing community. This works on the social interactionist premise that knowing is naming (Denzin 1992), hence the need to break away from the dominating male-oriented lexicon of English that operates in the opposite direction of ascribing names to experience, limiting interpretation and the introduction of alternative experience. Turner (1992) illustrates this lack of a word to share a particular female experience from her work. A woman describes how both she and her partner are in paid work. They both come home at a similar time in the evening but it is always her that goes in to the kitchen to start preparing a meal. Her partner says that he would offer to do the cooking but she does it so much better

than he does. She describes how he is using flattery to keep her in her subjugated female place of the kitchen. She has had to share the experience in a story because there is not a word to describe the action or the perpetrator, for which she feels frustrated and muted. In this example she has described an experience for which there is no adequate word to describe, highlighting the silencing factor as flattery and relational harmony. Her desire to reclaim women's discourse is seen in the search for a neologism to capture the experience that would enable shared understanding across the gender divide. Within the context of my project, this muting is illustrated by the appropriation of the technical language of the institution and in the storied descriptions of shared experiences for which an appropriate word does not exist. Three specific examples standout: 1) helplessness, disorientation, exposure, 'fish out of water', 'out of control', being treated as a patient when not sick feeling on entry to the institution 2) responding to the environment and context intuitively with their body 3) the exhilaration, relief, exhaustion, achievement of birth.

The final strategy to overcome the muting process is to exploit the use of media platforms to give a voice to the muted groups. Ownership of bodily experience in the public space of an online forum, exploits the potential of the digital platform to shape a collective identity among the birthing woman community (Vacchelli 2018). Identity has been described as unintelligible unless located in a social world, emphasising a drive for such exhibition (Wainwright & Turner 2004). The use of narrative through this platform offers the story as a site of resistance, and therefore an activist practice by challenging the inequalities in birth power relations within the current configuration of the UK birth system. Vacchelli (2018) describes this problematizing of dominant discourse in the public domain to present an opportunity to redress certain representations from the starting point of the personal in the story. Stories can index values within a shared activity, recreate the significance of behaviours and make meaning, binding women together into a community that resists individualist notions of a private life. If public appearance is considered a reflection of the inner self (Morris 2015), the story sits as a considered medium to manage that appearance to the community and to the self. Within the context of my project, these stories also emphasise the power differentials and their movement within the experiences of birth and offer a challenge to the subjecting identity of the institution (Lunceford 2012, Salmon & Reissman 2013). As the body has become an object of intervention by the institution, these storytellers are reclaiming the object as subject, connecting modes of being through their embodiment (Wainwright & Turner 2004). This subjectification is acted upon in a discourse of protest through the use of the digital platform of the 'mum's forum'. It is creating an opportunity for political activism to share alternative experiences of narrating the self and doing the birthing body (Misztal 2003).

Chapter 7 Conclusion

7.1 Contribution of my project

My project has highlighted counter-narratives to the dominant discourses of birth currently active in the UK. The domination of the medical narrative and its associated discourse of risk and safety controlling birth, has been seen to crowd out women's agency in 'doing the body' in labour. In many storytellers the risk discourse appeared internalised to create a short circuit of violence. Storytellers performed an evaluation of the self, according to the criteria of others, creating an anxiety over what they could become. This epitomises Foucault's discussions on bio power and Rose's application of this ideology to the health context and expert controlled society (Foucault 2004, Rose 1999). The mapping of identities onto the body could be seen through the performativity of social norms in labour. For example, being nil by mouth in labour in preparation for potential intervention 'because I'm an older mum'.

Historically, women's bodies have been the source of their subjugation through their alignment with the unpredictability of nature, and latterly through the power dynamics contained within Rose's neoliberal 'project of the self' (Rose 1999). This emphasised the importance of control among the storytellers as a criterion for childbirth. This concept is the antithesis of unpredictability and dependence which carry a pathological classification in a neoliberal society operating with autonomy as its central concept. The need for control can be described as closing the boundaries that are opened by the vulnerability of birth. Technology, in the form of technocratic support for birthing, was seen by some as offering control over the unpredictability of their body, and access to a higher level of rational culture. The use of communication technology in the form of the internet to post the birth stories of this project could be seen as a form of meta-control over birth, and as offering an opportunity for political solidarity. However, while acting as a site of resistance, the mum's forum on the internet also acted as a site of suppression. This illustrates the flow of power discussed by Foucault (2004). When the stories were first sampled, they were freely posted without restriction in a publicly accessible section of the site. Returning to the site at the end of the project, to ensure a lack of traceability of the original posts with any potential identifying excerpts used within my project, this section was gone. The site had undergone significant changes in layout and design. It was flooded with sponsored adverts and the birth story section contained a selection of positively worded excerpts from a careful selection of stories. They were presented as quotes with no photos and no opportunity for people to leave comments. Furthermore, in a different section of the site were recruitment adverts for 'return to work' NHS staff, clearly targeted at getting Mums back to work. The apparent move

from an independent site of advocacy for women to one aligned with the dominant forces in birthing in the UK is a disturbing example of women silencing women for financial or political gain.

Furthermore, those unchallenged positive birth stories of empowerment and achievement whitewash the experience of birth that the storytellers of my project and the reviewed literature tell, feeding the censorship of women by women. This new message that is being broadcast subscribes to Hays ideology of 'intensive mothering' first proposed in the 1990's, that expects a self-sacrificial and self-serving mothering (and that includes birthing) practice that re-domesticates women through motherhood (Ennis 2014). This patriarchal ideology is fuelled by the maternal advice, control and surveillance by 'experts'. Models of good mothering are pushed on women during pregnancy. For example, scientific findings have linked exposure of the fetus during birth to the flora of the woman's vagina to an improved immune system, leading to the swabbing (or seeding) of newborn babies with the mother's vaginal flora (Domingez-Bello et al 2010). Another growing area of investigation is in epigenetics where what you eat in pregnancy can influence the chemical markers on the genes of your child and predispose them to obesity, diabetes, heart disease, anxiety and even schizophrenia (Gaillard 2015, Reynolds et al 2013, Yajnick & Deshmukh 2008). Thus the control of women's bodies and their behaviour is extending into the health experiences of the next generation, ascribing accountability and guilt to women and their actions.

Evidence within the stories of defence against vulnerability highlighted the importance of relationality in both the birth experience, and in its telling. This vulnerability in interaction is because the self is constituted by relations with others. Denial of that relation will undo it and leave a lasting emotional response. For example, the self is exposed to harm by frustration of its desire for agency (there is no birthing pool available) or connectivity (you are not a priority for admission). If suffering is not acknowledged, the storyteller was seen to experience violence of the vulnerable by engaging in 'practices of the self'. These originated from learning about their self from communication with the environment around them such as giving up control of their body in labour (and their birth belief model) in exchange for relationality with the (incongruent) birth team - characteristic of a social model of birth; or renouncing the need for relationality and retreating to self-sufficiency at the risk of isolation and inability to emotionally cope with the experience.

Many of the storytellers positioned themselves according to shared assumptions with their online forum audience, utilising the dominant lexicon and discourse at key points of their story to perform legitimacy in their experience. This incorporation of medical language augments their own invisibility, perpetuating a collective understanding of who is in power.

However, this example of linguistic submergence of the woman's identity is counteracted by the storytellers' tentative reclaiming of the language of the unpredictable body and of emotional ways of knowing. The body as a site of resistance was also apparent in the regaining of agency at a critical point in the labour and storying the reclamation of their body as their own. The embrace of an emotive, body-based language for birth is shared in highly reflective, visceral accounts that emphasise the power of story in the reflective construction of meaning. Such content highlights the story as a political tool to redefine and reinforce ways of doing birth.

7.2 Limitations of the project

The small number of participants that contribute to the data set of my project and the specificity of their experiences could be regarded as the primary limitation of this project. With approximately 680,000 births a year in the UK (ONS 2018), 20 stories provide a mere snapshot of those experiences, giving no more than an insight for those English speaking, digitally active women who wrote a story on this particular online web forum. I have not interacted with the participants who wrote the stories, missing out perhaps, on a valuable relational component central to a qualitative research approach. However, the methodology of this project intentionally chose an online site from where to sample the stories to enable analysis of the dialogic co-construction of the stories with the perceived forum members, rather than with a researcher. While this approach requires acknowledgement and reflexivity in my interpretation and representation of the stories, it removes any opportunity to return to the storyteller to see if their story has changed over time, to ask for feedback on my representation of their stories or to compare how they may be framed for a different audience. The design of this project has restricted my ability to explore the storyteller's motivation for posting their birth story in a publicly accessible online space, and for exploring the woman's perspective of her potential audience to confirm or refute my assumptions in this section of the analysis. Consequently, my approach works solely with the 'text' of these accounts. Furthermore, some may find my personal experience of childbirth a threat to my interpretation of meaning in the analysis of the data. However, I feel that using an autobiographical method in my reflexive approach that explores my subject position in relation to the data, offers a transparent account of my personal and political engagement with the issues raised through my project.

7.3 Recommendations for the future and practical applications

My project did not set out to offer solutions to an extremely complex sociological landscape of birth in the UK. Instead, I wanted to look at birth stories, at how they act as a medium to transfer messages and culture around birth as well as serving a function to the teller to make meaning of their birth experience in relation to their expectations and of their transition to mother. During this project I also shared that journey, moving my position within the project from a midwife researcher outsider to a mother, sharing knowledge with the storytellers that needed no words to explain. It is interesting that a major finding of my project is the muting effect of the language used in birth. When I returned to my data after experiencing birth, my connection with the data, my interpretations and meaning making were visceral/body-based and emotional. Through my cross disciplinary exploration of identity, performativity and vulnerability within birth, I have tried to expose and connect the silencing factors while seeking the language to give voice to the findings of my project. At the beginning of this project my objective was service improvement. From my new insider subject position, my objective is advocacy and solidarity that begins by raising awareness of the complexity of doing birth in the UK context.

I feel this project has contributed evidence to the discussion of women's experiences of subjectivity in the discursive landscape of birth, while uncovering previously unacknowledged sites of resistance. The linguistic restrictions, sustained by the neoliberal control mechanisms on society and the self, act to shape the reality, feelings and expressions of birthing women. Naming these silencing strategies, as I have done through the findings of this project, and celebrating women's discourse on birth as the explosion of birth stories across the internet is doing, offer bold moves to challenge the muting status quo of women in birth.

An important component of the reflective process is to look back on my project and ask if I would make the same choices again. It is very clear from the thread of my personal story that runs through this project, charting my learning and processual becoming that this project was context dependent. I made the choices with the resources and knowledge I had. This project reflects growing awareness of the intersection of my identities on my approach to the data as much as what 20 women told about their births. At the end of this project, I am very different from who I was at the beginning and I would design the study differently as a result. However, I can take this learning forward and build on the findings of this project within my objective of advocacy from a position of solidarity. Fundamentally I feel reclaiming women's language for birth and working to create a new vocabulary encapsulating the experiences of birthing women would present opportunities for the issue of birth, and women's experiences of it, to occupy greater political space with a confident and decisive voice.

Understanding the turbulence women face in their birth journey, to which this project makes a contribution, can inform my post doctorate advocacy agenda for differently configured birthing services, supporting the pursuit of women's needs. Promoting spaces for women to talk freely about doing birth and what it means for them, like the original birth forum and story format of this project, could provide an attractive arena for a follow up project to expand the linguistic choice available to describe experiences of birth. This would work on the symbolic interactionist premise that knowing is naming, creating words from within a community to describe the exclusivity of that experience to their self and to others outside of the birthing community. This could offer an opportunity for inductive advocacy in the challenge to birthing systems that are reportedly not meeting the minded body needs of birthing women.

Appendix 1

Academic achievements since PhD registration in October 2012

Courses

Oct 2012 - July 2014 Middlesex University, London **PGCert in Social Research Methods** (first class)

Grants

Burdett Trust for Nursing £5000 awarded May 2019 for interview component of:
A feasibility study of the Oxford Video Informed Consent Tool (OxVIC™) and its impact on the perioperative decision-making experiences of people undergoing oncological surgery.

Publications

MacLellan,J. (2019) Vulnerability in Birth; A Negative Capability. *(Submitted to Journal of Clinical Nursing under review Sept 2019)*

MacLellan,J. (2019) The Storying of Birth. Health: An interdisciplinary journal for the social study of health, illness and medicine. (*under review*).

MacLellan,J. Fourie,S. (2019) Lived experience of women with faecal incontinence following childbirth: A thematic synthesis. Primary Health Care. doi: 10.7748/phc.2019.e1541

Taylor,J.E.B. Surey,J. **MacLellan,J**. Francis,M.L. Abubakar,I. Stagg,H.R. (2019) Hepatitis B vaccination uptake in hard-to-reach populations in London: a cross-sectional study. BMC Infectious Diseases 19 (1) DOI: 10.1186/s12879-019-3926-2

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